Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Virginia Irene Mageè 1999 24, 6:05 PM DEC 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 6. Sex Months Davs Hours 1□ M 2□ F Yrs. 54 AUG 13, 1945 Maryland 212-46-6751 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits N/A 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2109 Sidney Avenue 21230 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Counselor Drug Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Harold Magee Maizie Virginia Edwards 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace C. Blanchard/friend 2109 Sidney Ave., Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/27/99 Baltimore, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland, Inc. Thomas 299 Frederick Rd. Baltimore, MD 21228 Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 → Winknown 1 Tes 2 No 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23e or 28a-f ehow adical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina.

Director

Funeral

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Completed

Be

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with the Meryland

Examiner Physician/Medical þ Completed

physician and s the buriel-transit ettending p signed by the e is certificate has director, page 2 After this funeral efter deal Director:

certificate be executed 10 Certification:

DECEM

VIRGINIA MACER

n 24 hours efter des ne Funeral Director pletely filled in by th To the within 2

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State Registrar

edical

29b. Signature and Itie of certifie

25. Was cese referred to medicel examiner?

1 ☐ Yes

27. Manney of Death

1 Natural

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

2016

5 Pending investigation

6 ☐ Could not be

obart C. Inwin 31. Date filed (Month, Dey, Year)
DEC 2

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) MD

28a. Date of Injury (Month, Day Year)

Hospital:

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospica

28d. Describe how injury occurred

28. Place of Death (Check only one)

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Sparid 121 Marsh Law. the tenth of the second of the second of the 132 Mars 134 Frankling (1818 1919)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Neme (First, Middle, Last) 2. Dete of Deeth December 24 1999 6:25Am **Physician** Mary Ellen Myers /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** North Arundel Hospital Glen Burnie Anne Arundel Hours Min. 8. Date of Birth (Month, Dey, Year) SEPT 4, 1925 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Deys 10 M 20 F Months 220-14-3615 Maryland Director Usuel Residence of Decedent 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylen Department of Heelih and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show with jury or other traumatic event, the Medical Examiner mantles in Lifted an once. 10e. Stete 10d. Inside City Limits Pasadena 1 Yes 2X No Director Anne Arundel 10f. Zip Code 21122 10e. Street end Number 10g. Citizen of Whet Country? USA 1211 June Way Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 XNo Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 11, Maritel Status Bleck, White, etc. 1 Never Married 3 Married 1 ☐ Yes 2 ☒ No Specify: If Yes. Give Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 11 Self-employed Business Owner 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Edward P. Cusack Anna Maria Matey 19a. Informent's Name/Reletionship (Type, Print) MARY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles W. Myers/husband 1211 June Way Pasadena, MD 21122 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriet 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 12/24/99 Baltimore, MD 21. Signature of Furreral Servica Licensee 22 Name end Address of Facility
Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** · CHEONIC OBSTRUCTIVE LUNG \$11 EASE Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner PNEMMONIA physician end s the bunel-trans Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) Records, P.O. Box 68760, law requires that the death certificate be-Physician/Medical Due to (or es e consequença of) Pert It. Other stgniftcant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital I or Attending Physician: after deeth. Director: After this certifica 25. Wes case referred to medicat director Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P Innatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Death Certification: 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1-DNaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) tCertifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner stated. Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 30 Neme and address of person who completed cause of death (Item 23a) (Type, Print)

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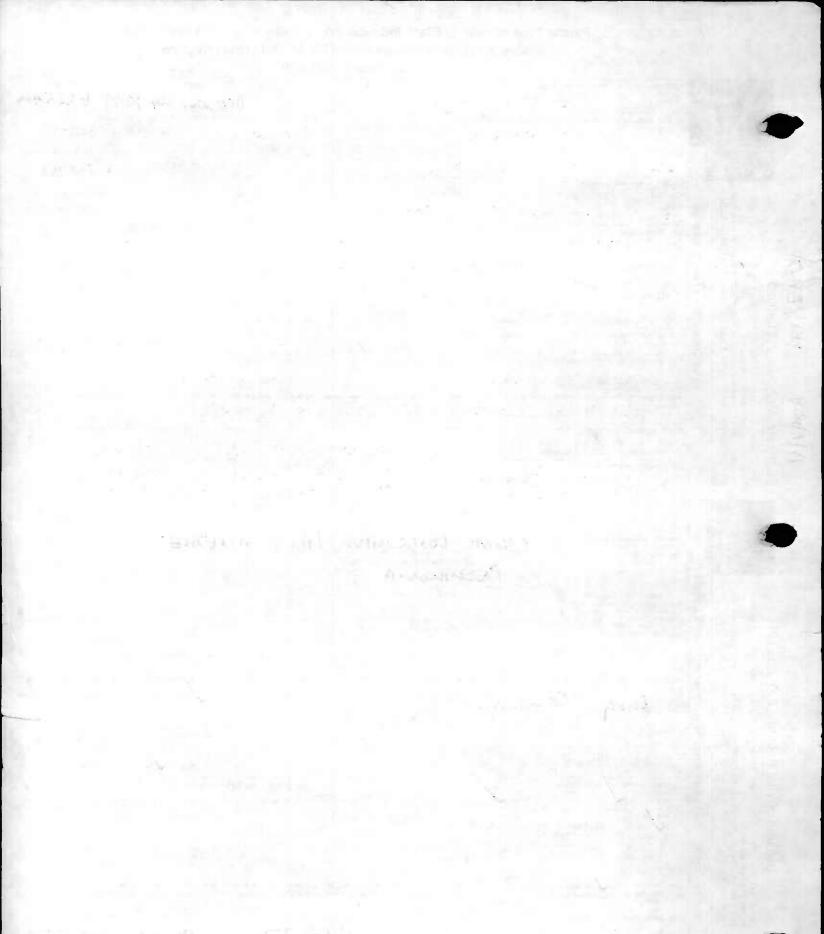
301 Howard A iten Brome. MA

Registrar

31. Date filed (Month, Day, Year) DEC 2 8

32. Prigistrer's Signatur

DHMH 16 Rev 6/95



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 27, Betty Lou Mancill-Fila DEC 1999 11:00 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Deys Months Hours 216-32-6811 63 AUG 29, 1936 Tennessee Usual Residenca of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Director Annapolis N☐ Yes 2☐ No 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 650 Americana Dr., Apt. 103 21403 Funeral USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: P A White 3 ₩ Widowed 4 Divorced Completed 16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education fy only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Banking Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Unk. 2 Myrtle Currier 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald T. Mancill, Jr./son 8287 Larkspur Dr., Baldwinsville, NY 13027 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 12/28/99 Baltimore, MD nature of funeral Service Liograpes
Thomas Gregor 22. Name end Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Physician/Medicai Due to or es e consequence of): à rement Panciestete shuusin Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? Chinic osstuctuil Pulning disune-sevel. 1 XYes 2□ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appetient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth 1 Maturel 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

physician and s the burial-transit 68760 Box P.O. | Records, of Vital al or Attending Physician: The selfer death.
I Director: After this certificated in by the funeral director, pa Division To the Hospital or Atterwithin 24 hours efter der To the Funeral Directo completely filled in by the

Funeral

Director

28a-f show

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"natural", or

permit. Pages 1 end 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, I'm Madie...

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier

29a. Certifier

(Check only one)

DO8314

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
900 ROLE (. SAMARAS M.D. 205 Ridgely Ave. Awwapolis; M.D.

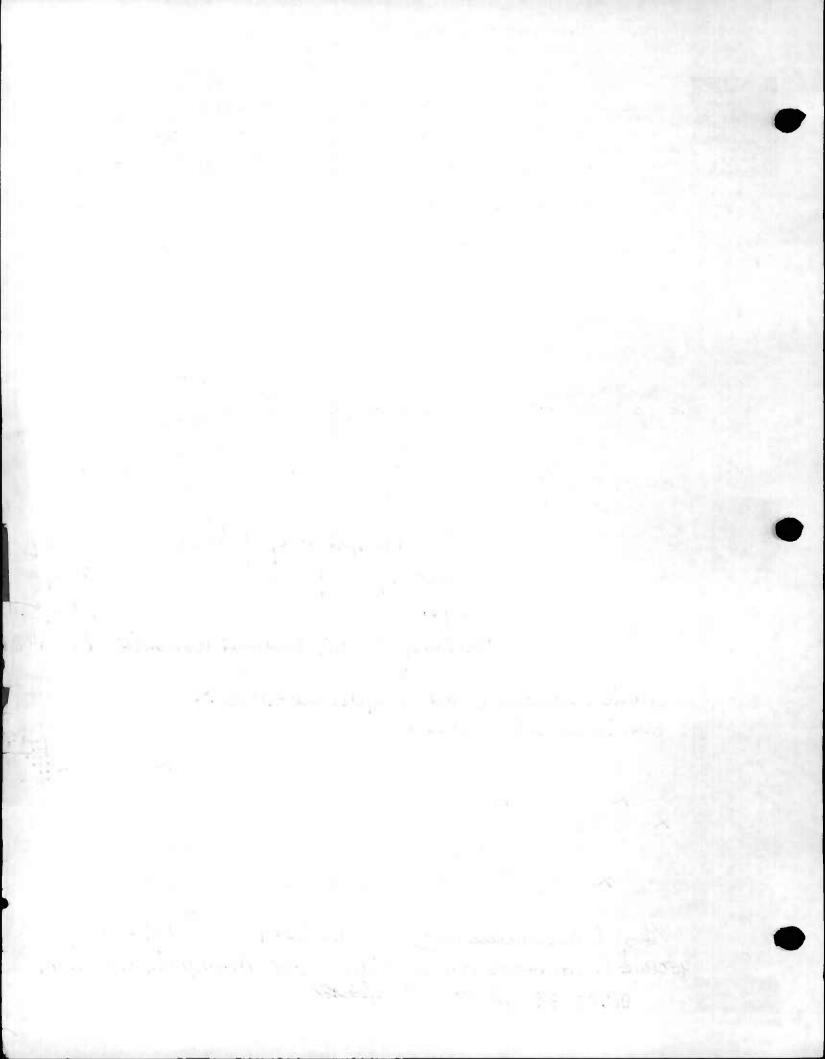
State Registrar

Medicai

DEC 28

32. Registrer's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month **Physician** DECEMBER 23,1999 /Medical Dity, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva straet and number) Examiner THE JOHNS 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) DEC 22, 19 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (Steta or Foreign Country) **Funeral** Hours Months Days 1₩ 2□ F 217-94-8573 1965 Director Georgia Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits MD N/A Baltimore 1 Yas 2 □ No Directo 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 23a or dical Examiner must be 3524 Greenspring Avenue 21211 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 'natural', or Items 14. Race - Amaricen Indian, 11. Marital Status Black, White, etc. 1 Nevar Marriad 2 Married Saltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yas 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 10 Furniture Sales Self-employed permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If flam 27 is marked oth any injury or other traumatic event 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Oscar J. McKenzie, Sr. Rosa Harrison To 19a. tnformant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) Father Oscar J. McKenzie, 3524 Greenspring Ave. Baltimore, MD 21211 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Metro Crematory, Inc. 12/24/99 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, MD ²² Neme and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Furthral Service Links Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximata tritarval Batween Onset and Death **Physician** Immediate Ceusa (Final disaasa or condition rasulting in death) /Medical SEPS 15
Dua to (or as a consequence of): Examiner b. VANCOM VCIN-LESISTANT ENTEROCOCCUS

Dua to (or as a consequence of): Sequantially list conditions, if eny, laading to immediata ceusa. Entar Undarlying Ceuse (Diseesa or Injury and c. human immuno deficiency VIRUS

Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical that initieted events rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END STAGE CENAL DISEASE Records, 24b. Wara autopsy findings available prior to complation of ceusa of death? CRYPTOCOCCAL MENINGITIS 24a. Was an autopsy 1 Tas 2 No 1 ☐ Yas 2 ☑ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was casa rafarred to medicel axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: ∮ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Medical Certification: To 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, streat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 18 Certifying Physician: To the best of my knowledge, daeth occurred at tha time, dete end plece, end dua to the ceusa(s) and mennar es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier

State Registrar

DHMH 16 Rev 6/95

SHANNON J. WINAKUR, MO; JEHNS HOPKINS YLOSPITAL; 600 NORTH WIFE SMEET; BALTIMORE NO21287 31. Data filed (Month, Day, Year) 1999

J. Mil

29b. Signatura and titla of certifiar

30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print) 32. Registrar's Signatura

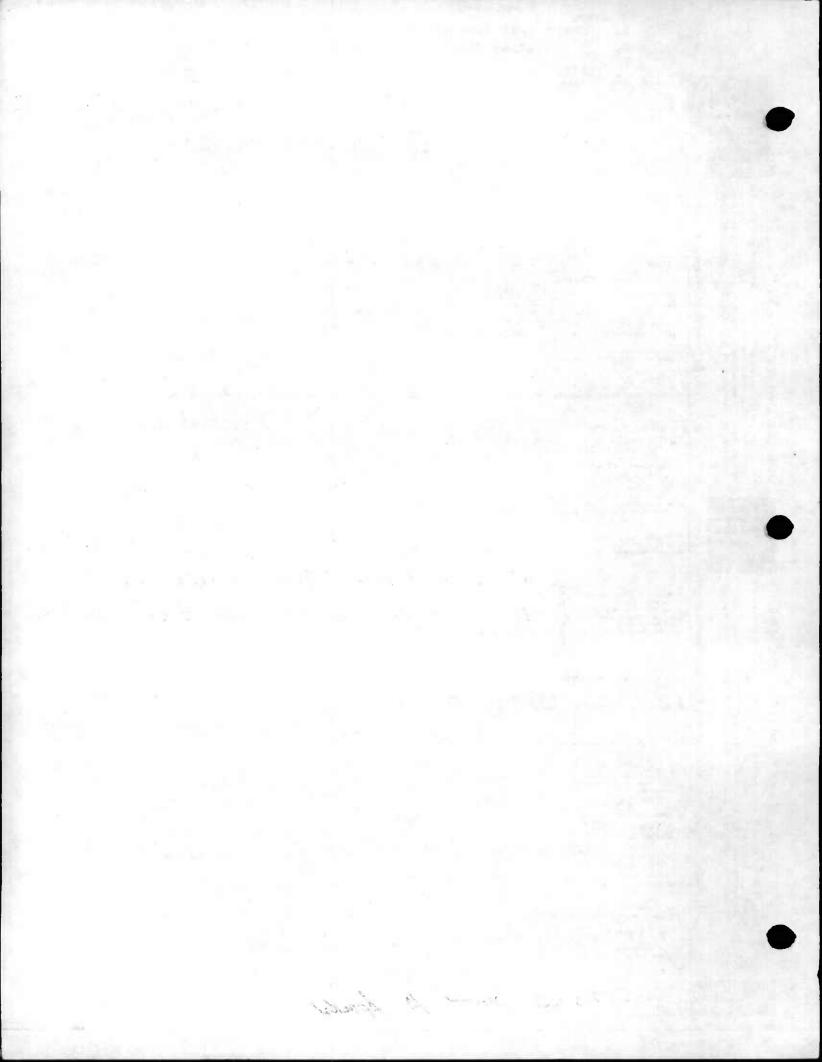
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29c. Licanse number

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29d. Data signad (Month, Day, Year)

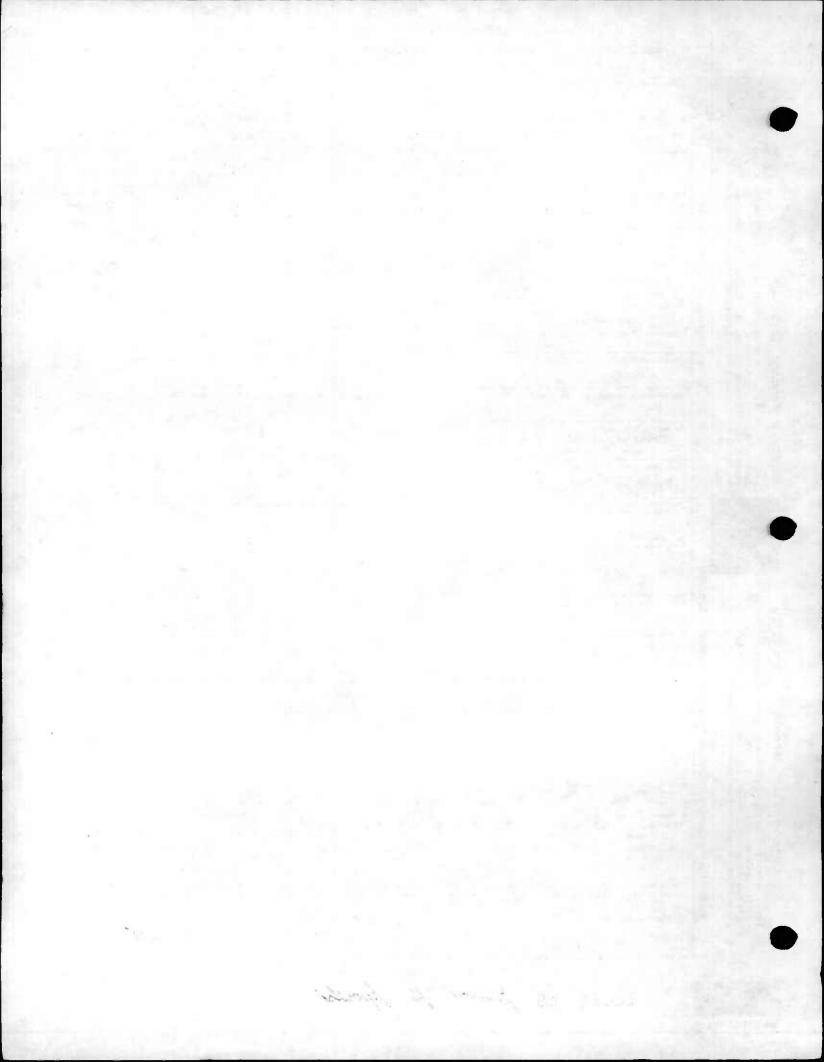
DECEMBER 23, 1999



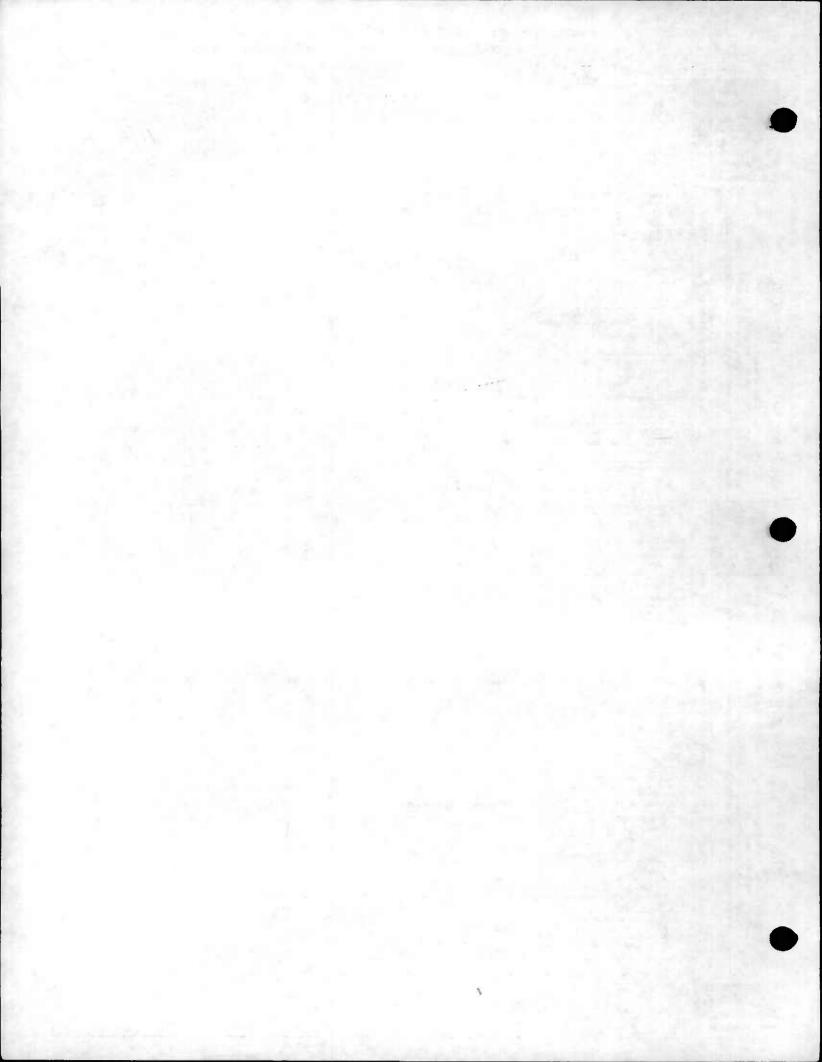
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an			t Doroth	v M	loore				Month	donth Day Year 3:03		
al er	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Local									ath 4c. Cou	inty of Death	
21 21			HOSPITAL	CEN	ITER			ROSED	PALG		ACTIO	
	5. Sociat Security Number	If Unde	r 1 Year	If Under 24 Hrs Hours Min.	8. Date of I			nplace (State or Foreignitry)				
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2	10e. Street and Number	21110		-	Daiti	_	o Code			10g. Citizen	of What Co	
runeral Directo	8503 White	Mea	dow Lane	9		101. 24	212	36		Tog. Onzen	USA	ondy ,
	11. Marital Status	1	2. Was Decedent E	ver in U	S. 13. V	Vas Dece Yes, spe	dent of H	ispanic Origin? (S In, Mexican, Puer	specify Yes or I	No- 14.1	Race - Amer Bleck, White	
	1 Never Married 2 Me 3 Widowed 4 Divorce		1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	lo				Specify:				hite
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2			is Peter	cson	1					Myrt1e		
	19a. Informant's Name/Reletion					_		end Number or R				
	Peggy Maeser	/ 51	ster	Joon D				Meadow		_		MD 2123
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Re	emovel from State	C	Place of Dispos cemetery, crem	etory or	other plac		Date	20c. Locati	on - City or 1	own, Stete
	4 Donation 5 Other			Met			-	Inc. 12/			imore,	MD
	21. Signature of Funeral Service		Vieson		27	rema	nd Addres LION	ss of Facility Society	of Man	cyland,	Inc.	
	Thomas Gr	egor	0					rick Rd.				.8
	23a. Part1. Enter the disease, shock, or heart failure. Lis	or complicationly on	cations that caused e cause on each lin	the deat	h. Do not ente	er the mo	de of dyin	g, such as cardia	c or respiratory	errest,	1	Approximate Interval Between
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	tmmediate Cause (Finet disease or condition resulting in death)	a.	PNEUr	70n	IA						1	IWEEK
5					or as e consequ	uence of)):					
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I	Sequentially tist conditions, if any, leading to immediate		Due to (or es e consequence of):								1	
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ᄝ	resulting in death) Last		Due to (or es a consequence of):									
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	25. Wes case referred to medic examiner?	-	20.1 200 31 00011 (01001 011) 010)									
2	1 Yes 2 No	H	ospital: 1 Inpatier		ER/Outpatient 3□ DOA Other			4 LI Nursing I	Home 5□Re	e 5 Residence 6 Other (Special		cify)
con micanoli.	27. Manner of Death 1 ☑ Natural 5 ☑ Pend	ing	28a. Date of Injury (Month, Day Year)				Wor		28d. Describe how injury occurred		curred	
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		ior	end manner ste	led.		29	r Licens	e number		29d Date si	nned (Monti	Day Year)
Ш	29b. Signature and title of certifier 29c. License number 29d. Date signe 12/3									12	1211	. 55, . 66,
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M	30. Name and eddress of perso	n who cor	mpleted cause of de	eath (Item	23a) (Type, F	Print)	C	No.	, 3	, ,	one j	7 . 20
	30. Name and eddress of person DR. CARCLYN	7A	mpleted cause of de	ath (Item	FRANKI	Print)	Squ	are Uni	JE, BAC	timo RG	mai	ryland, 21.
	30. Name and eddress of perso	7A	mpleted cause of de	eath (Item 2000 C. Signa	FRANKI	Print)	Squ	are Uni	VE, BAC	Jim . RG	MAI	eyland 21

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.



S. Scoil Scourity Number S. Scoil Scoi	sician		1. Decedent's Name (First, Middle, Last) JONATHAN MCCRORY , JR.							Dey 23. 199					
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29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)	ert		1☐ Certifying Phy Medical Exam	iner: On the bas	is of examina	wledge, deeth occur tion end/or investiga	red at the tition, in my	time, date and plac opinion, death occ	ce, and due to the cause(s) and manner es stated.						
The same Miles O.C.M.E DEC. 23, 1999	dicai Certif					29c. Licer	nse number				Dev. Year)				
	Medicai Certii	one)	title of certifier		290. Significance and title of certifier										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** BRIAN 415PM MOODY DECOURGE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BAGIMGE CITY BATIMORE HODITAL Inct hirthday) If Under 1 Yeer OF MAYUAND HOST 6. Sex 7. Age (In yrs. last birthday) UNIVERSITY If Under 24 Hrs Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Months Days 1 AM 2 F Yrs. 216 80 3950 01 - 30 - 1970Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD N/A Yes 2□No BALTIMORE Funeral Director 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 111 PARK AVENUE 21201 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Race - American Indien, Bleck, White, etc. Never Merried 2 Married 1 ☐ Yes 2 ◯ No Specify Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 NURSE **HEALTH** 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be PHILLIP DEAN EMILY MOODY 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stefe, Zip Code) KEVIN MOODY/BROTHER 208 N. GILMOR ST. 20b. Plece of Disposition (Name of cemetery, crematory or other place) BALTO MD 21223 Date 120c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □ Cremetion 3 □ Removel Irom State 4 □ Donation 5 □ Other (Specify) KING MEMORIAL PK 12/29/99 BALTO., MD 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility JAMES A. MORTON & SONS FUNERAL HOMES, INC. 1701 LAURENS ST. BALTO., MD. 21217 23a. Part/. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) Due to (or ea e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last IMMUNO DESCRIPTION VIPUS HUNTON Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 Yes 2 No Completed by 24b. Were eutopsy lindings eveilable prior to 24a. Wes en eutopsy performed? completion of cause of death? 2 X No 1 ☐ Yea 2 ☐ No 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manger of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? Natural

The lew requires that the death certificate be asscuted P.O. Box 68760, 17. 180 es signed by the at d be detached to Division of Vital Records, hes After this certificate or Attending Physician: director. funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun.

Funeral

Director

8

or Nema 23a

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permit. Peges 1 and 2 should be filed w
Department of Heelth and Mental Hygien
Important: if Nem 27 Is marked other th
eny Injury or other traumatic avent, the
page.

Physician

/Medical Examiner

death

filed within 72 hours after

21215-0020

Baltlmore, Maryland

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, Ierm, street, lactory, office building, etc. (Specify) 4 Homicide

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

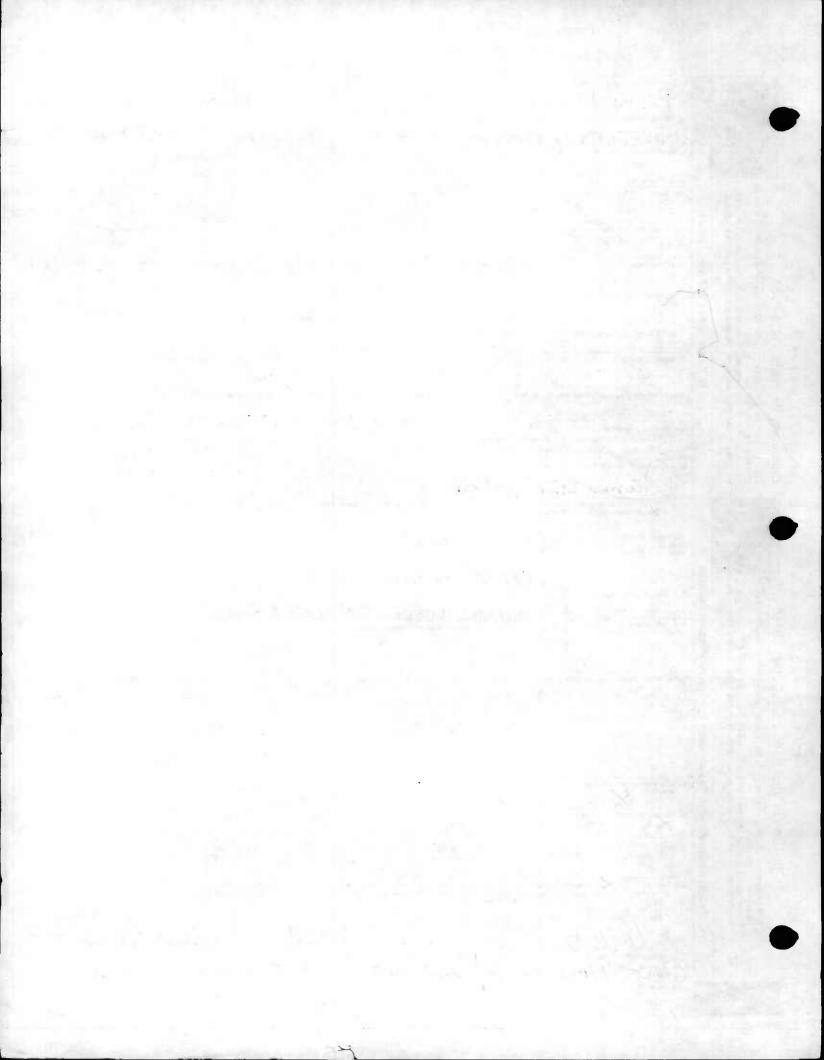
Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARANDAL 22. SOUTH GREATE STREET. BATTIMOPE, MD 21201 32. Registrar's Signeture

State Registrar

edical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day Dur Land us 2) 15 **Physician** 4c. County of Death MCE Vin AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Randallstown Baltimore Northwest Hospital Center If Under 1 Yaar | If Under 24 Hrs. Months | Days | Hours | Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 216-24-1872 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sax **Funeral** 1 M 2 F Yrs. 70 14,1929 Balto. June Director Usual Rasidence of Decedant 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylan Department of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Exercises must be notified at once. 1 Yas 2 No Director Reisterstown Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21136 13011 Old Hanover Road Funeral USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Was 2 No If Yes, Giva 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White Be Completed by 3 □ Widowed 4 □ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Tree Service Tree Trimming 12 th Grade 0 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Grace Treger 2 <u>Calvin O. McElhattan Sr.</u> 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 13015 Old Hanover Road Reisterstown, Md, 21136 Mrs. Debbye L.DiMarino 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval irom Stata 12/28/99 Finksburg, Md. 4 Donation 5 Othar (Specify) <u>Evergreen Memorial</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road ELINE FUNERAL HOME ans Reisterstown, Md. 21136 lene 23a Parts. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical myvardisc Infaretion **Examiner** Dua to (or as a consequence of): Examiner lard-UMY physicien end the bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 88 signed by the ettending to be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? should should Completed 24a. Was an autopsy performed? After this certificate has funerel director, page 2: 21 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. injury at Work? 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida

that the death certificate be executed 55x 68760, Division of Vital Records, P.O. The lew requires Physician: Hospital or Attending Pin24 hours after deeth.
 Funeral Director: After the letaly filled in by the funeral To the Hospital or Atterwithin 24 hours after developed To the Funeral Director completely filled in by the

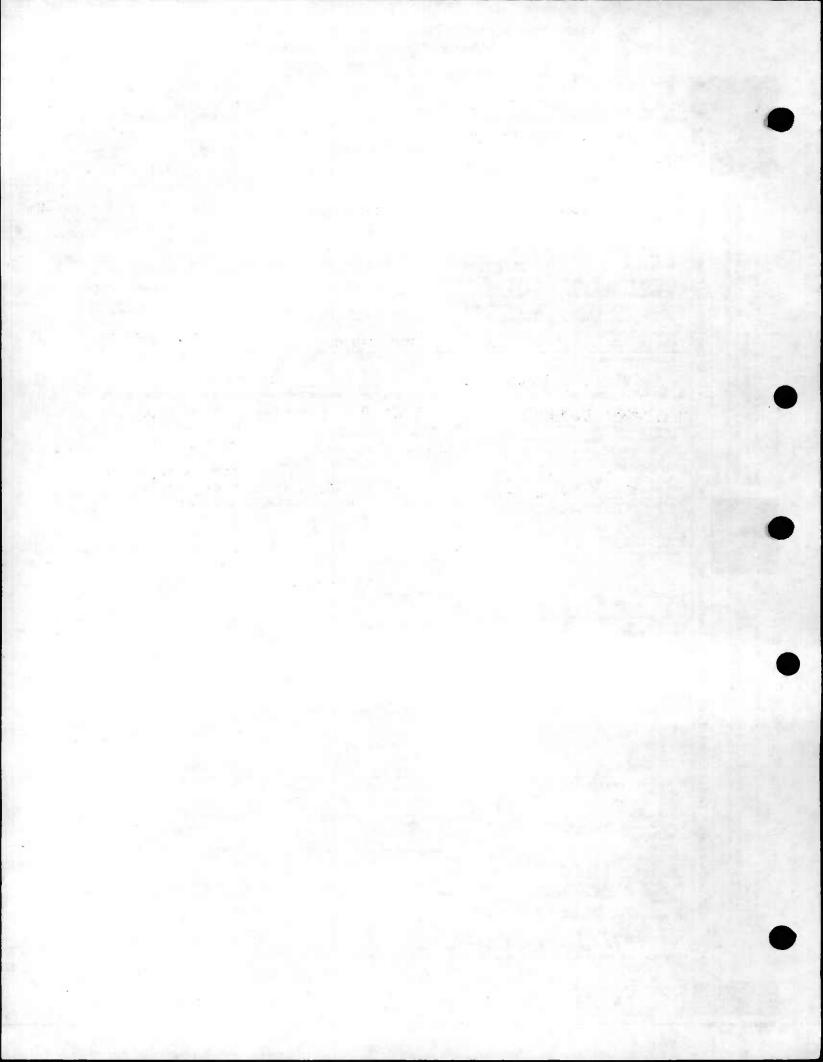
yland 21215-0020

Baltimore,

one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	gation, in my opinion, death occurred at tha	tima, data and place, and dua to the cause(s)
29b. Signatura and titla of certifiar	29c. License number	29d. Data signed (Month, Day, Year)
plice 1-1six	143974	Dusumber 33, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Alike Hisish Northwest	Hoppital	kandalle town, md
31. Data iiled (Month, Day, Year) 32. Registrar's Signatura		
DEC 2 8 1999 Server G. Lagar	61	
	0.30	

112 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

State Registrar 29a. Cartifiar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Day Month Physician 25, 1999 1 P.M. EARL LEE MOORE Dec. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Reisterstown 29 Caltriders Lane Baltimore Birthplace (Steta or Foraign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1♥M 2□ F Yrs Director Frederick, Md. 220-50-1937 July 7,1948 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Reisterstown Md. Baltimore 23a or 25a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Caltriders Lane 21136 USA Funeral 'natural', or hama dical Examiner m 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11, Marital Status Never Married 2 Married filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cockeys Enterprises Refuse Removal Worker 7 th grade 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important; if Item 27 is marked oth any Injury or other traumatic event alone. Be 2 Rosella M. Garrett George Moore 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29 Caltriders Lane Reisterstown, Md. 21136 Mrs. Rosella M. Moore 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Service 12/28/99 Hampstead, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136 amy time 231. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) Large Cell Lymphons /Medical Examiner Due to (or as e consequence of): Physician/Medical Examiner physicien end a the burlei-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): aigned by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown P 24b. Ware eutopsy tindings eveilabla prior to completion of cause of death? Completed 24a. Was en autopsy performed? is certificate has director, page 2 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only ong) Other: 4 Nursing Homa 5 Masidence 6 Other (Specify) 1 | Yes 2 | 10 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: After thi completely tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide edical 11 Cortifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and due to the cause(s) and mannar es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

State

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

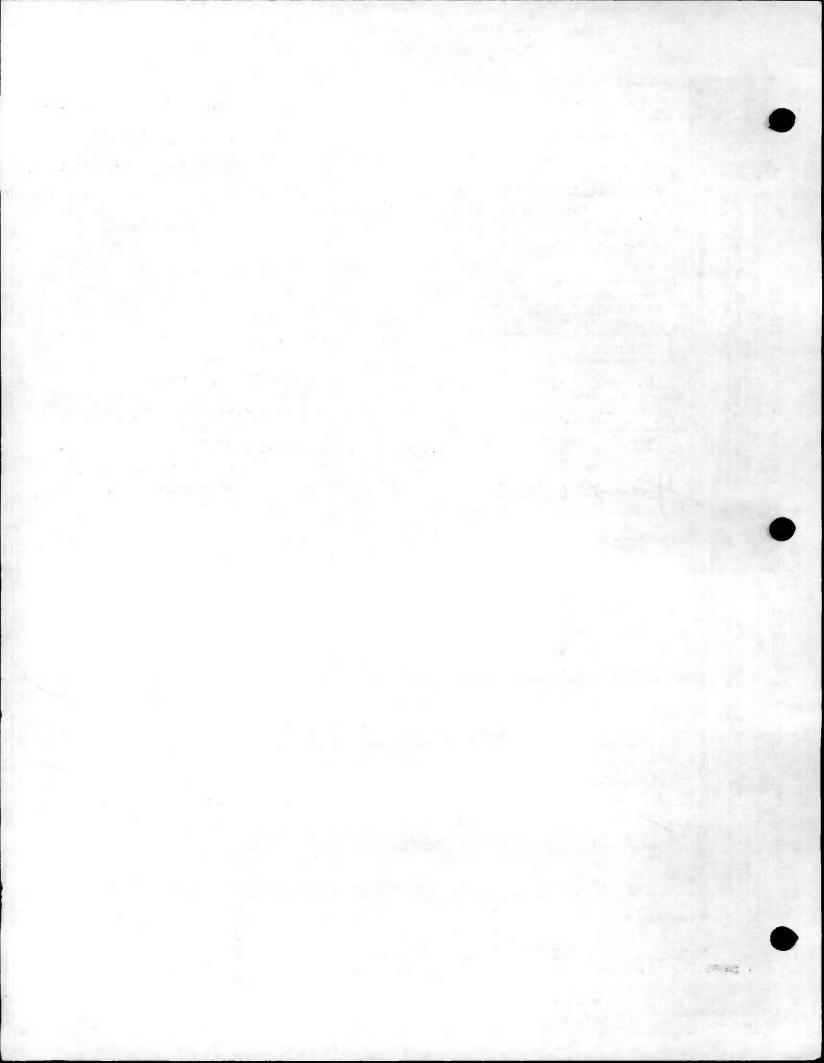
DEC 2 8 1999

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c License number

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Deçedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Markows December 27, 1999 5:55 AM pocation of Death /Medical 4a. Facility Name (If not institution, give street end number 4b. City, Town, or Location of Death **Examiner** VA Extended Care 5. Social Sacurity Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□ F Months 218-14-9690 Director 9, 1926 Maryland Usuet Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental hygiene. Important: If them 27 is merked other than "natural" ---- any injury or other traumetic evants. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1804 Winford Road Funerai 21239 U.S.A. 12. Was Dacedent Ever In U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates:1945-47 1 Never Married 20 Married by 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Cotlege (1-4or 5+) Sales years Insurance 17. Father's Name (First Middle Last) Be 18. Mothar's Name (First, Middle, Maiden Surname) John 2 Markowski Frances Peitzrak 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mildred Markowski (wife) 1804 Winford Road Baltimore, Maryland 20b. Ptaca of Disposition (Neme of cametery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriat 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 12-28-99 Baltimore, Maryland 21. Signature of Funerat Servica Licansee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 ten 23a. Part1. Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between **Physician** Onset and Death Pneumonia /Medical tmmediate Cause (Final disease or condition resulting tn death) **Examiner** Due to (or as a consequenca of): The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 MG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how tnjury occurred or Attending 5 Pending investigation o the Hospital or Attending Whin 24 hours after death. O the Funeral Director: Altr 1 ☐ Yes 2 ☐ No 2 Accident 8 6 ☐ Could not be determined 3 Suicide ď Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide filled in Cartifying Phyetclan: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 29b. Signature and tiple of certifie 29c. Ltcensa number 29d. Date signad (Month, Dey, Year) 6/0220

State Registrar

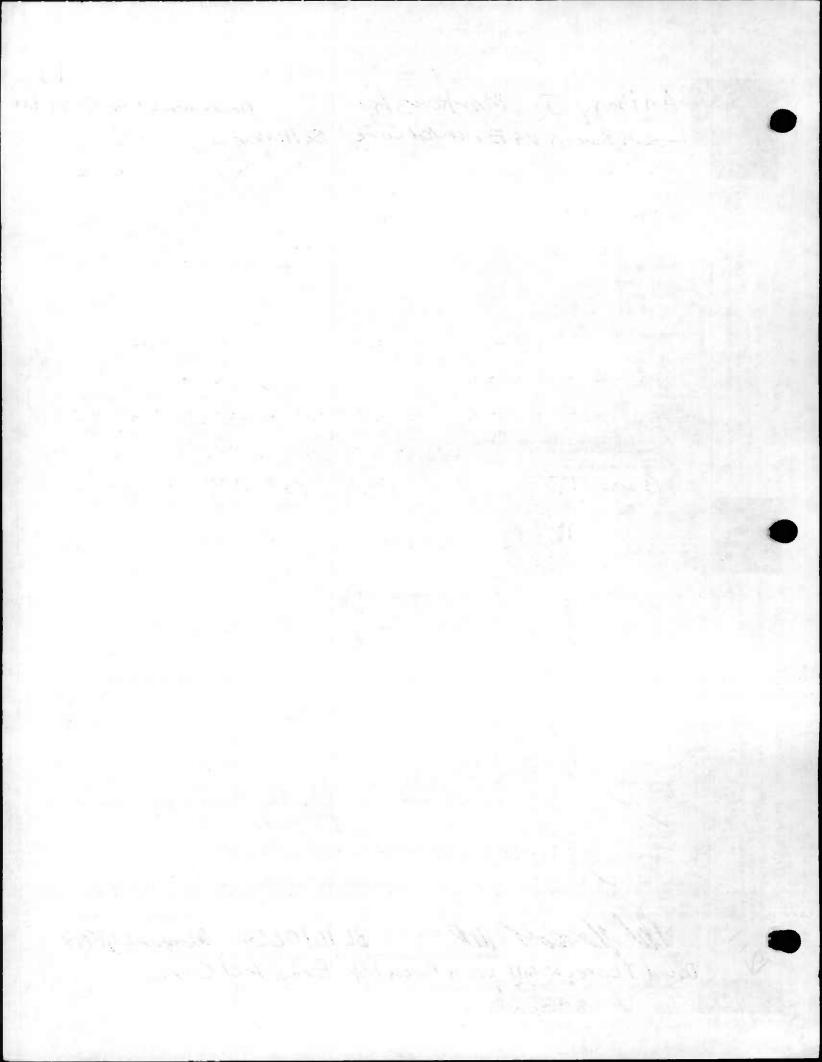
31 Date filed (Month, Day, Year) DEC 28

Loch 32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (ttem 23e) (Type, Print)

Extended Care

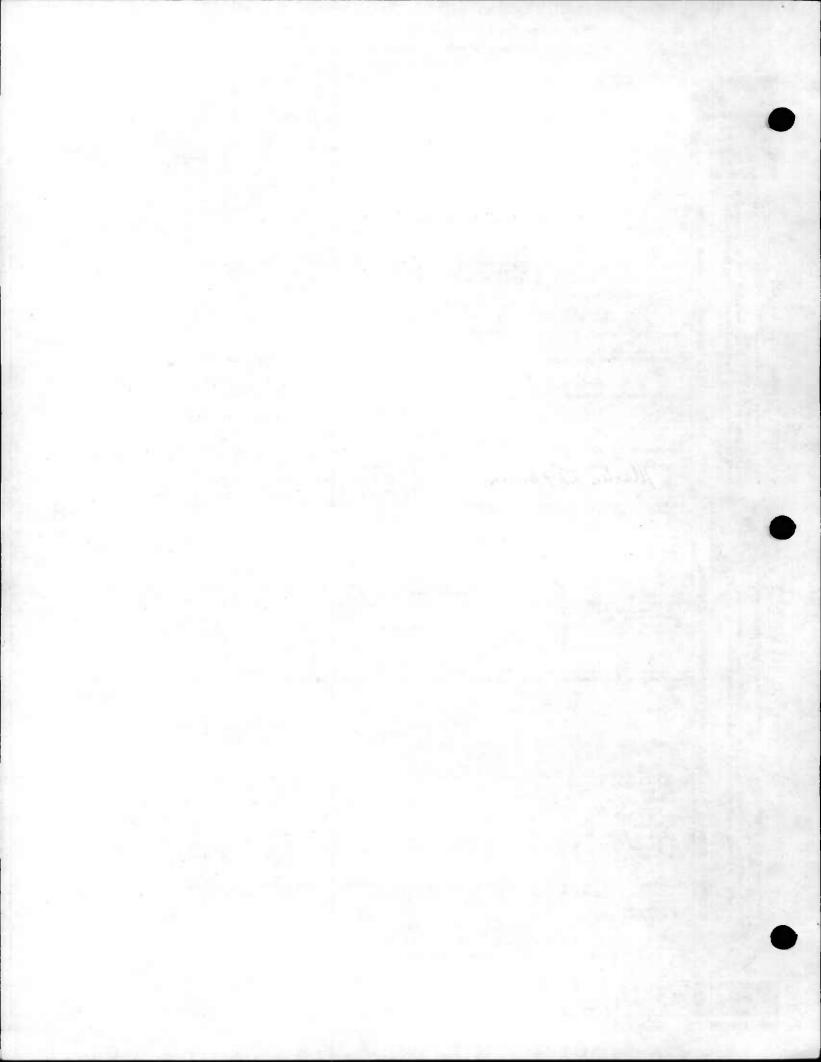
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death **Physician** EDITH MAY BAYRLE McGLONE 23, 1999 4c. County of Deeth /Medical 4b. City, Town, or Location of Death 10:05 PM 4e Fecility Nema (If not institution, give street end number) Examiner HOSPICE OF BALTIMORE: GILCHRIST CENTER Baltimore County 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□M 257F Director 166-01-1560 Feb 4, 1914 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore County Directo Anneslie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 509 Windwood Road 23 21212 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo It Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indien, Black, White, etc. 11. Meritel Status 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 TWidowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Residence 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental H lant. If Item 27 is marked off Be Charles Anthony Bayrle Freida Bertha Neiderhauser 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. J. Matthew McGlone (Son) 6904 Avondale Road, Baltimore, MD 21212 Saltimore, 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify) St Mary's Ch Cemetery 12/28/99 Homeland, Maryland 21. Signatura Funeral Service Long 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. Dewson 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart feiture. List only one of use on each line. **Physician** Cervical cancer Immediate Ceuse (Final disease or condition rasulting in deeth) /Medical 3 mm this Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence ot): P.O. Box 68760, that initieted events resulting in deeth) Lest Due to (or es a consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings avellable prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) HOSPICE 1 Yas 2 No Medicai Certification: To this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28h. Time of 28d. Describe how injury occurred 28c. injury et Work? Affer 1 Neturel 5 Pending invastigation 1 Yes 2 No 2 Accident after deat Director: 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d Data signed (Month, Day, Year) December 24, 1999 D25205 mo 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) N. Charles St. Balto. Ind 21204 GRIMC 100 6701 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State Denever DEC28 Registrar

DHMH 16 Rev 6/95

December



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

	19b PER FH					Cer	tificate	or	Death	100:	Reg. No	1)	400	12
n	1. Decedent's Neme (First, Middle, Last) WESS MULLIN									2. Date of Death Month Day DECEMBER 25 19			3. Time (
al er	4e Facility Neme	(If not institution	. give street a	and number)		TIOHHI	14		4b. City, Town, or L	DECEMBER 25 1999 17:33 or Location of Death 4c. County of Death				
ı	THE JOHNS HOPKINS HOSPITAL BALTIMO											N/A		
Ī	5. Sociel Security 050-54-5	Number	6. Sex							8. Date of B (Month, D Sept.		rth 9. Birthplace (State or For Country)		
	Usual Residence					30				Jept.	7,1301	1101	7 10110	
	10a. Stele	10b. County			10c. City, 7	Town or Lo	cation						10d. fnside	
Director	Pa.	L	ancast	er	Ep	hrata					Selia -		1 □ Ye	s 2 🔯 No
2	10e. Street and N	umber 35 Be	thann R	Road			10f. Zip (code	10 193		10g. Citizen of	What Cou	ntry?	
	28 Bet	hany Ro	ad-					17	522		U.S.A.			-116
1	11. Meritel Status		12. We	es Decedent Ev med Forces?	ver in U,S.	13. V	Vas Decede Yes, speci	nt of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	lo- 14. Ra Bla	ce - Ameri	can Indian, etc.	
-		1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Yeer or Detes:							Specify:		Speci			
	190	15. Decedent	's Education	nloted)	1	16a. Deced	ent's Usual	Occup	pation	rina	16b. Kind of E	Business/In	dustry	
Completed	Elementery/Sec			ellege (1-4or 5+)		Coll		during most of work d)		Credi	Credit Collec		on
000	17. Father's Neme	(First, Middle, I	.ast)						18. Mother's Nem	e (First, Middle	e, Maiden Suma	me)		4 4
2	Thoma	as Mull	in						Charlo	tte W	olf			
	19e. Informent's I			int)		19b. Meilin	g Address	Street	and Number or Ru	rel Route Num		, Stete, Zij	p Code)	
	Susan L	. Mullir	/ Wife	е		35 B	ethann than	Ro	ad, Ephrat	ta.Pa.	17522			
1	20e. Method of Di	sposition			20b. Pled	e of Dispos	sition (Nam	of of		Date	20c. Location	- City or T	own, Stete	
		2 ACremetion 5 □Other (Sc		ol from State			emator			/31/99	Leola	Da		
1	21. Signeture of F				Lvui			~	ess of Fecility	31/33	Leola	ra.		1 100
	1	1		19	1				eiler Inc.				d 212	221
	23a. Pert1. Enter shock, or he	the diseese, or eart failure. List	complications only one caus	s thet caused to se on each line	he death.	Do not ente	or the mode	of dyir	ern Avenue ng, such es cardiac	or respiretory	more, Man	rylan ¦	Approximation of the Consett end	etween
	Immediate Cause disease or condit	ion	. CO	RONARY	ARTE	RY DT	SEASE					1	UNKNO	
	resulting in deeth)	a. 00			s e conseq			- 27				UNKNO	ATA
			DI	DIABETES MELLITUS						UNKNOW				JN
	Sequentially list of	onditions,	b			s e conseq	uence of):				4.5			
	Sequentially list of if eny, leading to cause. Enter Und Ceuse (Disease of	Immediate derlying		cDue to (or es e consequence of):								i		
3	thet initiated even resulting in death	IS	с									1		
			d									1		
Physician/Med	Pert II. Other sign	ificant condition	not resulti	ng in the ur	nderlying ca	use giv	ven in Pert I.	23b. Die	d tobecco use c	ontribute 1	to the cause	of death?		
										1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn] Unknown	
completed by											s an autopsy formed?	a	/ere autops vailable prio ompletion of	rto
												of	death?	
										1 ☐ Yes 2 ☐ No 1 ☐ Yes			□ Yes 2	No
	25. Wes case refe examiner?	erred to medical	Hospite	4.				100	26. Place of Dear	th (Check only	one)			
2	1 Yes 2	VOutpatien		-	4 LI Nursing m		ne 5 Residence 6 Other (Specify)							
ation:	27. Menner of Dec 1 Neturel 2 ☐ Accident	oth 5 ☐ Pending investig		. Dete of Injury (Month, Dey	Year) 28	Bb. Time of Injury	M 28	Work?			e how injury occu	ow injury occurred		
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi		. Plece of Injur building, etc.		e, farm, str	eet, fectory,	office			(Street and Num own, Stete)	ber or Rui	ral Route Nu	imber,
edical c	29e. Certifier (Check only		xaminer: Or	n the basis of e	examinetion					place, and due to the cause(s) end manner es stated. occurred at the time, date end place, and due to the cause(s)				e(s)
Med	one) 29b. Signeture en			nd manner state					se number		29d. Date sign			
	1	ML												
	RES -000										DECEMBER 25 1999			

DHMH 16 Rev 6/95

State Registrar

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

JOHN AWAD MD 600 NORTH WOLFE ST

BALTIMORE, MD 21287

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dey **Physician** OWENS December ENISE 1999 111: 25 AM 77 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Hop Kins HOSPITA NA Johns more 5. Social Security Number 220 - 64 - 723 If Under 1 Year 7. Age (In yrs. last birthdey) 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 20F Months Days Hours Min Yrs 11 - 11 -Director Md Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiens. Important: If item 27 is marked other than "naturel", or itema 23s or 28s-f show way fujury or other treumatic event, the Medical Examinet must be notified at ones. 10b. County 10c. City, Town or Location 10d. Inside City Limits Balto 1∰ Yes 2 No Ma N. A. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Detes: 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Never Merried 2 € Merried Baitimore, Maryland 21215-0020 1□ Yes 2⊠No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Md. SING Lottery Customer dense itep, 124 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 inknown UTNIPSERG 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8199 Williamontellen Lenf HETN 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1. Burial 2 ☐ Cremetion 3 ☐ Removel from State 12/28/90 .13 4 ☐ Donation 5 ☐ Other (Specify) VAR 8 M 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Locks M Locks 23a. Pet1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart teilure. List only one cause on each line. Approximete thervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical · metastatiz breast 4 years Examiner Due to (or es e consequence of) been signed by the attending physician and ahould be detached for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of VItal Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Appatient 2 ER/Outpatient 3 DOA 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, lectory, office building, etc. (Specify) 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Certifier 155 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) Thi Vally 5000 December 21 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital 31. Date tited (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

ORIGINAL

Registrar **DHMH 16 Rev 6/95**

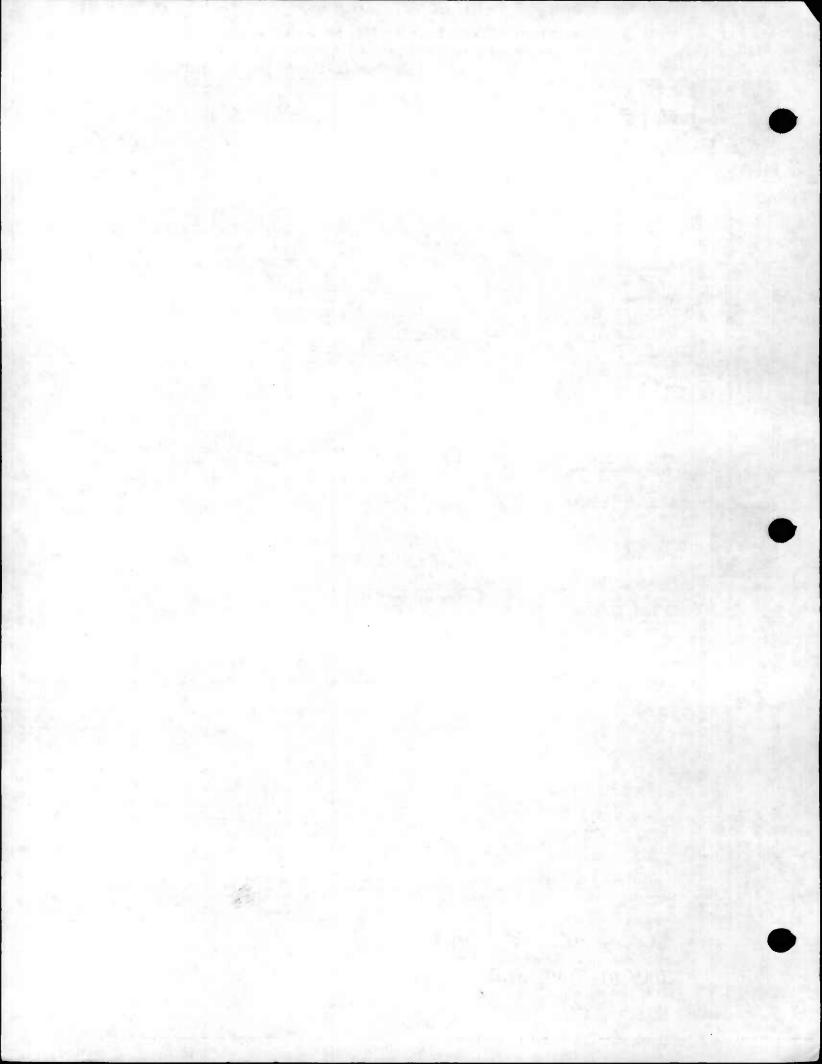
State

JACK M. TITUS

MID.

1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 60515 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death De Cember Pay **Physician** 1999 10-4 7am MOTVA /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner baltimore Baltime Cit Hospital 0 sina H Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | 08 - 18 26 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F Birthplece (State or Foreign Country) **Funeral** 141.16.3449 13 Vrs Known os Cluton Sylvester Director Usual Rasidence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth end Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahov any injury or other traumatic avant, the second file injurier mass to notified all bottles. 1 Yas 2 No Director BALTIMORE MD NIA 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4030 BOARMAN AVENUE 21215 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No If Yas, Giva Year or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, etc. 11. Marital Status 1 Navar Married 2 Married 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST WHARE HOUSE 12 TH GRADE NA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) CECIL MOORE PENELOPEPE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 285 MALCOLM X BLUD, BROOKLYN NY 11233 LOUISE MOORE | DAUGHTER 20b. Plece of Disposition (Nema of cematery, cremetory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 12.28.99 OWINGS MILLS, MO GARRISON FOREST 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Service Licenses Dan C H VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PLKE, BALTO. MO. 21229

23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest,

Approximation Auditass of Pacility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALTO. NATL PLKE, BALTO. MO. 21229

Approximation Auditass of Pacility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALTO. NATL PLKE, BALTO. MO. 21229

Approximation Auditass of Pacility

VAUGHN C. GREENE FUNERAL SERVICE

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VAUGHN C. GREENE FUNERAL SERVICE

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Approximation Auditass of Pacility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALTO. NATL PLKE, BALTO. MO. 21229

Approximation Auditass of Pacility

Approx Approximete Interval Batween Onset and Death **Physician** Heart dispase /Medical Immediata Cause (Final Many ys disaasa or condition rasulting in death) Examiner thet the death certificate be axecuted Sequantially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initioted events rasulting in death) Last Dua to (or as a consequenca of): Box 68760 Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Wara eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours after death.
 Funeral Director: After this cardificiately filled in by the funeral director. 25. Was gasa rafarred to medical exerginar? Be 26. Placa of Daath (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1104 es 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Me har of Death 28d. Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide 1🗹 Certifying Physician: To tha best of my knowledga, daeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. To the Hosp within 24 hou To the Fune complately fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the tima, data end plece, end due to the cause(s) and mannar stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-19-1999 00021639

Registrar

State

30. Nama and addrass of person who completed cause of deeth (ttem 23a) (Type, Print)

ASHRUK

32. Begistrar's Signatura

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DEC 2 8 1999

31. Dete filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #18 PER FH G7.78 12/27/99 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** 3:25Am December 25, 1999 GARY E MILL
4a Fecility Neme (If not institution, give street and number) MILLER /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner square Hospital Losedal Baltimore enter 0 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 10 M 20 F Months Days Hours 62 Yrs. 217-38-1565 Director 10-26 PENNSYLVANIA Usual Rasidance of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits ? Is marked other than "natural", or fems 23s or 28s-f short treumstic event, the Madical Examinar must be notified as 1 Yes 2 No Director BALTIMORE CI 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21214 5906 BURGESS AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 In No If Yes, Give 1961 - 1963 Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Married 2 Married 1□ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hygiene 120 NA TRUCK DRIVER PARTS 18. Mothar's Name (First, Middle, Maiden Sumame)
ELLA MAE GILLS 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental merked HARRY D. MILLER ROBERTA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2:
Department of Health as Important: if Nem 27 is eny injury or other treuponce. 5906 BURGESS AVE BALTIMERE MD 2/2/4
ce of Disposition (Nama of Date 20c. Lodation - City or Town, State ROBERTA A. MILLER Baltimore. 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition 1 Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) 12/29/99 BALTIMORE, MD PARK MORELAND MEM. 22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. 21. Signeture of Funeral Service Licensee 6009 HARFORD ROAD BALTIMORE, MD 21214 LIC DOCC 02 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical 2 Weaks ure na Examiner Due to (or as a consequence of): Physician/Medical Examiner Sta sician and bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): attending physician for use as the buna Box 68760 that initiated events resulting in death) Last Due to (or as e consequence of) USB as signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Wara autopsy findings aveilable prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physicien: 25. Was casa raferred to medicel axaminar? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Natural death. 1 Tyes 2 TNo investigation 2 Accident Director: 3 Suicide 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 24 hours after d Funeral Direct pletaly filled in by 4 - Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. To the Hosp within 24 hor To the Fune completaly fi edical 29a. Cartiflei (Check only one) 29b. Signature anti/title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12-25-99 00055010 addrass of person who complated causa of death (frem 23a) (Type, Print)

State
Registrar

DHMH 16 Rev 6/95

Franklin

32. Registrar's Signature

01

1999

31. Date filed (Mon

Square Drive Baltimore, Maryland 21237

99-7628-031 Ernest Crothers Maxwell III

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMENDED ITEM #24a PER ME VERBAL G778112/27/99 AH Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Ernest C. Maxwell, III December 19 1999 07:12 AM. /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12715 Atherton Drive # Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Months | Days | Hours | Min. | Feb. | 14, 1935 Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplaca (State or Foreign _ Country) **Funeral** Months 1以M 2□ F Yrs. 200-24-2915 64 Director Usual Rasidenca of Decedant 10a State 10c. City, Town or Location 10b. County 10d. Insida City Limits or 28s-f show XX Yas 2 □ No Directo Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 12715 Atherton Dr. USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Important: if them 27 is marked other than "naturel", or theme 23e any injury or other traumatic event, the Lea Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No 1957 – If Yas, Give Yaar or Datas: 1959 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Nevar Merried 2 Married 1 Yes 2 No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) Printer Newspaper publishing 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Ernest C. Maxwell, Jr. Mary Rachel 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carrie Maxwell, wife 12715 Atherton Dr. Silver Spring. MD 20906 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NUMBER Richland Mausoleum 12/24/99 Johnstown, PA 15904 21. Signetura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Meek FH 1312 Graham Ave., Windber, PA 15963 23a. Per 1. Entar the disease, or complications thet caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heer feilure. List only one cause on eech line. Approximate Interval Betwaen Onset end Death **Physician** tmmediate Cause (Finel disaasa or condition resulting in death) /Medical Contact Gunshot Wound of Chest Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Ceuse (Disease or injury Due to (or as a consequence of) P.O. Box 68760. that initiated evants rasulting in death) Last Dua to (or as a consequence of) signed by the a Pert If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings availabla prior to complation of cause of daath? Be Completed 24a. Was an autopsy 1√ Yas 2 No 1 ☐ Yas 2 ☐ No certificate of Vitai Attanding Physician: fuheral director. 25. Was case raferred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 EP/Outpatient 3 DOA 1 No Yes 2 No Certification: To the state of 28a. Data of Injury
Fu (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After Division 5 Pending investigation Fernium 1 Natural To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fuh. self subject shot 1 Yas 2 No 2 Accidant 12-19-99 709 A 6 ☐ Could not be detarmined 35 Suicida 28f. Location (Street and Number or Bural Routa Number, City or Town, Steta) 12715 Atherton Dr. W. 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida silver Sprin trel home Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and mannar as stated.

20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. December 20, 1999 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Chuten 32. Aegistrar's Signatura

J

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Dey Month Physician John E. McKinley, Jr. December 25 1999 0014 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Fallston General Hospital Fallston MD Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 3, 1932 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 1₩ M 2□F 213-28-3973 67 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits PA York Delta Township XXYes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? must be r 148 Highridge Road 17314 United States "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes XX No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes X No Specify: Specify: White 3 ₩idowed 4 Divorced Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Policeman Law Enforcement 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important; if hem 27 is marked other any injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John E. McKinley, Sr. Lena Myrtle Hudson 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robin L. Ark / Daughter 148 Highridge Road, Delta Township York PA 17314 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Department | 2 Cremetion | 3 Removel from State | 4 Donation | 5 Other (Specify) Moreland Mem. Park Cem. Dec. 29, 1999 Baltimore MD 21. Signelure of Funeral Service Licensee Wictor P 22. Neme end Address of Fecility Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Pert1. Enter the disease, or complications that caused by wealh. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical . Acute myscardial infaction 3 days Examiner nckinley Examiner CARDIOVASCULAR Arterioscierotic nding physician and use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Physician/Medical Due to (or es e consequence ot): signed by the e P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3☑Probably 4☐Unknown mellitus Diabetes Records, þ Completed 24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? PARKINSON'S DISEASE 1 □ Yas 2 ₽ No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: B 25. Wes cese referred to medicet examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpalient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Metural 5 Pending deeth. To the Hospital or Attandit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Dale signed (Month, Day, Year) MB December 25, 1999 D25027 person who completed cause of death (Item 23a) (Type, Print) BELAIR MO 21014 YANKAR 2 NORTH AVE 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

Physician /Medical Examiner lew requires that the death certificate be axecuted Box 68760,

Physician

/Medical

Examiner

MD

Director

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Completed

Funeral

Director

e filed within 72 hours after death with the Manylen of the frame 23e or 28e4 show vent, the Medical Exemples must be notified at

permit. Pages 1 and 2 should be filed v
Department of Health and Mentel Hygies
Important: if Itam 27 is marked other th
any Injury or other traumatic event, the

Baitimore, Maryland 21215-0020

page 2 funeral

Exam physicien and Physician/Medical been signed by the a ahouid be datached ģ Complated cartificate Attending Physician: Ba this Hospital or Attending
 24 hours efter deeth.
 Funerel Director: Aftereight filled in by the fun

P.O.

Records,

Vital

Division of

Cartification: To

State Registrar

edical

31. Date filed (Month, Day, Year) DEC28

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

29c. License number 1) 36974

28c. Injury at Work?

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

DEC 26 1999

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE IPTUXENT PRICEIPT DAUD U. NYANTOM MO Columbia 21044

32. Registrar's Signature oaks

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hosp within 24 hos To the Fune completely fi

Your Labor Systems and the Control of the Control o Destroy Control

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey 3, 1999 8:41AN **Physician** Margaret Notarc /Medical 4a Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ba Himore Hospital Cen 7. Age (In yrs. last birthday) Manklin Square sedale Center 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country), 6. Sex **Funeral** 10 M 20 F Days 217-20- 8839 Usual Residence of Decedent 77 Yrs. Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show Baltimore 1 ☐ Yes 3 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? agramore Rd. 21237 raro, Margare 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after copariment of Health and Mental Hydiene. Important: if item 27 is marked other than "natural", or then any injury or other treumatic event, tre Medical Franch and 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nomemake 6 VRS nome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 08 KOERNER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8002 Sagramore Socuse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, cremetory or other place)

EVANS FUNERAL CHARGE-BOUR 1999 FOREST HELD

22. Name and Address of Facility EVANS FUNERAL CHARGE Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, but as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 21234 Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardia 40 Minutes Examiner Due to for es a consequence of): Physician/Medical Examiner Bradyarrhythmic physicien and s the buriel-transit The lew requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inibated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Cerebrovascular Accident 1 Yes 2 No Division of Vital Records. Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: After this certific funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation ne Hospital or Attending in 24 hours after death. he Funeral Director: After pletaly filled in by the fun 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 \$ 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, 17 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks

DHMH 16 Rev 6/95

Registrar

DEC 2 8 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** MILDRED NELSON December 13,1999 7:42 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GOOD SAMARITAN HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2XTE Months Days Hours Yrs. 88 Director 213-05-4521 MARYLAND July 18,1919 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 8 ra 23a 825 N. PATTERSON PARK AVENUE U.S.A. 21205 Funeral or Nems 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/CXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Stetus filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: Be Completed by 3 □ Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC i. Pages 1 and 2 should be filed w tment of Haalth and Mentel Hygien tant: If item 27 is marked other th ijury or other trsumatic svent, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE RESSIG MERCEDES UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tri any Injury or other tri page. PAT DOOR/ FRIEND 8167 BAYSIDE DRIVE, PASADENA, MARYLAND 21122 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 12/17/99 BALTIMORE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. melile 21231 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner nosocomial The law requires that the death certificate be axecuted usa as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury URINARY IRACT thet initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by page 2 should be detac 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown à 24b. Were autopsy findings available prior to Be Completed 24a. Wes en eutopsy performed? completion of cause of death? this certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 100 Attending Physician: 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient Certification: To 1 Yes To the Hospital or Attanding Physi within 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral dir 2 ER/Outpatient 3 DOA 27. Menney of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 ONetural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

State Registrar **DHMH 16 Rev 6/95**

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Chauman

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Dept of Medicer

32. Registrar's Signeture

21215-0020

Baltimore. Maryland

P.O. Box 68760,

Records,

Division of Vital

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29c. License number

LOCHRAVEN BLUD

29d. Date signed (Month, Dev. Year)

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

LIVER AMI	END I	TEMS: #23 PART	State of Maryl I, 27, 28		ent of Health and		9	9 40	1522
		1. Decedent's Name (First, Middle, La	st)			2. Date of De Month		Year 3.	Time of Death
	hysician Medical	Marl	k Thomas 01	iver			20, 199		5:30 PM
E	xaminer	4a Facility Name (If not institution, giv			4b. City, Town, or				
		5. Sociel Security Number 6. S		man to an high death of Mills	Baltim		N/A		
	neral ector	219-06-5421	2DF 31	vrs. last birthday) If Un Yrs. Mon		(Month, Da	y. Year) , 1968	Country)	(State or Foreign
pue :	_	Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Location				10d In	side City Limits
Maryland	No.	MD N/A		Baltimor	e				XYes 2 □ No
with the	90	10e. Street and Number		10f.	Zip Code		10g. Citizen of V	Vhat Country?	
A S	diner must be notified Funeral Director	9 West Hill St	reet		21201		USA		
90	Je i	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Do	specify Cuban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	- 14. Raci	e - American Inc k, White, etc.	dian,
-0020 hours after death	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give		s 2X No Specify:		Specify		e
21215-0020 d within 72 hours af		15. Decedent's Ed	Year or Dates:	16a. Decedent's I	Isual Occupation		16b. Kind of Bu		
215-	it, the Medical	(Specify only highest gra	ide completed)	(Give kind of life. DO NO	work done during most of world use retired)	rking	TOO. TRING OF DO	isilioss/ilioosity	
	E W	Clementary/Secondary (0-12)	College (1-4or 5+) 4	Busine	ss Owner		Resta	urant	
ind Siled	evant Be (17. Father's Name (First, Middle, Last)			18. Mother's Nar	- 1-1-1-1			
should by Menta	To the	Harry W.					e Elli		
C 0 0	: ē	19e. Informant's Neme/Reletionship (Shelley J. 01:	**		ress <i>(Street and Number or Ri</i> n Ave., 4F				
Fealt Fall	- the	20e. Method of Disposition		b. Place of Disposition (·	Date	20c. Location -		
noi ages ant of	y or	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval Irom State		or other place) tory, Inc. 12	12.50	Balti		
Baltimore, Normalist Pages 1 end Department of Health	iny injury	21. Signature of Funeral Saffice Licer		22 Name	and Address of Facility	-			
m 40	\$ g	Momas Duzu		Cren	nation Socie				
		Thomas Gres 23a. Part1. Enter the disease, or com shock, or heart tailure. List only			Frederick R			Appr	roximate
Physi	cian	snock, or neart tallure. List only	one cause on each line.						vel Between et and Death
/Med Exam		Immediate Cause (Final disease or condition	NARCOTIC	AND ALCO	HOL INTOXIC	ATION			
Cxaii	441	resulting in death)	Due to	o (or as a consequence	of):			- 1	
De De	ial-transit Examiner		b						2017
), execu	Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	Due to	o (or es e consequence	of):				
3760, ate be ex	the bunal-transit	Cause (Diseese or Injury thet initiated events	C. Due to	(or as a consequence	nft:			1	
diffical display	Wed the	resulting in death) Last			·				
O. Box 68 the death certifical the whending on	page 2 should be detached for use as the Completed by Physiciar/Med	LEADING TO A STATE OF THE STATE	d						
O e de	/sic	Part II. Other significant conditions of	ontributing to death but not	resulting in the underlying	ng cause given in Part I.	23b. Did	tobacco use cor	ntribute to the	cause of death?
O = =	Ph					10	Yes 2 No	3 Probably	4 Unknown
Records, Families the law requires the	d by					24a Was	an autopsy	24h Were au	utopsy findings
	should						rmed?	available complet	e prior to
Vital Relicion: The lev	director, page 2					100	V 0∏N-	of death	2 No
Ital	Be Co	25. Was case referred to medical			26 Place of Dec	ath (Check only o	Yes 2□No	ILI Yes	2LI N0
of Vital Physician: T		examiner? 1 AYes 2 No	Hospital:	ER/Outpatient 3□	04		dence 6 Oth	er (Specify)	at
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Vision Attending or death.	the fu	2 Accident Investigation	round:	Found:	1 ☐ Yes 2 ☒ No	UNKN			
Division or Attending effer death.	led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - A building etc. (So FOUT	t home, farm, street, fed	tory, office	28f. Location (: City or To	Street and Numb	er or Bural Rou 1 S · A	NN ST.
phtaf ours	D 2	20s Cartifice 1 Cardidate Bb		-			DRE, MD		
Hos 24 hos Fun	pletely fill	29a, Certifier (Check only one) 1☐ Certifying Ph 2☐XMedical Exam	niner: On the basis of exam and manner stated.	ination and/or investiga	red at the time, date and place tion, in my opinion, death occu	red et the time,	cause(s) and ma dete end piece, i	nner as stated. and due to the o	ause(s)
Divisit	completely filled in by the funeral	29b. Signature and title of certifier			29c. License number		29d. Date signed	(Month, Dey,	Year)
	,	1 Wallette, M	Mull	da Ares	O.C.M.E.		Decem	ber 21	, 1999
1		30. Name and address of person who	completed cause of death (I	tem 23a) (Type, Print)					
		Yspyponn 1	1. KORTU H	W) 11	1 Penn Street	Baltim	ore, MD	21201	
P	State	31. Date filed Ment Dy, 8ear 199	9 3 Registrar's Si	mature /	ash!				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Daath Day Month Year **Physician** 25, Marion Larkin Oswald DEC 1999 1:00pm/Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Annapolis Anne Arundel H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 15, 1915 If Under 1 Year 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys 1 M 2 DF Yrs. 84 057-05-1565 New Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road 21401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Larkin Della Fallon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Ellen M. Murray/daughter 118 Roads End Ln., Severna Park, MD 21146 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial X☐ Cramation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 12/27/99 Baltimore, MD 21. Signature of Funeral Se Cremation Society of Maryland, Inc. Dawners McDonald 299 Frederick Rd. Baltimore, MD 21228 Approximata Interval Batwean Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceusa (Final disaasa or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hrknown (ancer à 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medical 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) Living Assisted 1 ☐ Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicida

The law requires that the death certificate be axecuted P.O. of Vital Records, or Attending Physician: Division e Hospital or Attending 1 24 hours after deeth. Funeral Director: Aft

Funeral

Director

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rai', or items 23a or 28a-f shov Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hydiene. Important: if tem 27 is marked other than "natural", or flee any injury or other traumatic event, the Mexical Exercities Pade.

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/Medical Examiner

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To the Hosp within 24 ho To the Fune completely fi

funerel director,

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Medical

29a. Certifier

(Check only one) 29b. Signatura m

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)
DEC 2 8 1999

Penin Jula

32. Registrar's Signature

ess of person who completed causa of death (Item 23a) (Type, Print)

rene Cz

Andd

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

3

21012

29d. Date signed (Month, Day, Year)

27/99

James Chambellain



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** December 20, 1999 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dwg **Examiner** 0 more If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/ Birthplece (State or Foreign Country) **Funeral** Days Min. Months Hours 18-67 1□M 2ØF Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location i end 2 should be filed within 72 hours after death with the Marylen teath and Merial-Hygiens, the state of 18 marked other than "natural", or flame 23a or 28e-f show her traumstic event, the Merian Train from the De hondrad and her traumstic event, the Merian Train flow. 1 Ves 2 □ No Director Varilland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2/20 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) gleni 17. Father's Name (First, Middle, Last) 18/Mother's Name (First, Middle, Maiden Surname) Be 0 2 a 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Stete, Zip Code) permit. Peges 1 and 2: Department of Health el Important: If Itam 27 is any injury or other trau Udom ohnson dal 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) U 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph 2222 W ray ame W. North Aue Ba 23a. Per 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and d for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Que to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate hes t 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical example? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Desidence 6 □Other (Specify) 28a. Dete of tnjury (Month, Dey Year) 27 Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Investigation Neturel n 24 hours after death. he Funeral Director: Af death. 1 ☐ Yes 2 ☐ No Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ò Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completaly fi (Check only one)

DHMH 16 Rev 6/95

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

119MA

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

19

MD

32. Registrar's Signature

29c. License number

DEST

29d. Date signed (Month, Dey, Year)

DHMH 16 Rev 6/95

State Registrar

herat, no 11055 Day, Year) 32. Registrar's Signature 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Yea **Physician** Paparides Andrew 4b. City, Town, or Location of Death 4 26 1999 6:52 am /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex. 1 AM 2 ☐ F 7. Age (In yrs. last birthdey) **Funeral** Months Days 177-01-5954 Yrs. oct. 7,1915 Mass Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Baltimore Director 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? U.S.A. Pinewood Avenue 21214 3009 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 SQYes 2 □ No IKYes, Give Yeer or Dates: 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Banking Broker Mortgage 12 marked other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) 1 and 2 should be Health and Mental Antonios Paparides Penelope 2001ots 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 26 Manor Springs Ct. Glen Arm, MD 21057 Mr. D. Apostolou 20e. Method of Disposition Dec. 28, Pages 1 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State ъ 1 Buriel 2 Cremetion 3 Removal from Stete netrios (emetry 1999 CubHill, Maryland 22. Name and Address of Facility Evans Chapel of memories St. Demetrios (emetery) 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Service Licensee 8800 Harford Rd. Baltimore MD sin Approximete Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each tine. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last physician s the bunal NEW MUNICA P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No signed I Division of Vital Records. à The law requires 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? page 2 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ 0 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? or Attending 5 Pending investigation 1 Neturet 2 Accident To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the ceuse(s) end manner stated. edicai 29a. Certifier (Check only onel 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 12-26-99 22530 30 Name and eddress of person who comp eted cause of death (Item 23a) (Type, Print) Hassan imi 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar DEC 2 8 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dec /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL AGNES Baltimore 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Yrs. 212-42-1837 NOV. 20. 1942 Maryland **Usual Residence of Decedent** 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1√ Yes 2 No MD. Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2106 Ashton Street 21223 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Raymond Waite Parks Alice Cullum 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Birmingham - sister 1029 Circle Drive, Balto., Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12/27/99 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State Baltimore Washington Crm. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. K. Marshal 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASYSTOLE GHT VENTRICLE FAMURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HYPERSENSION UMONARY Physician/Medical COPD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? COIDOSIS 1 Yes 2 No 3 Probably 4 Unknown OTHYROLDISM 24b. Were eutopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? AR DISORDER 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation Netural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner physician and s the burial-transit Division of Vital deeth.

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu

Funeral

Director

"natural", or items 23s or 28s-f

Saltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy fireportant: If them 27 is marked other any futury or other traumatic sevens.

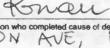
Physician

Registrar

31. Date filed (Month, Day, Year) DEC 2 8 1999

29b. Signature and title of certifie

29a. Certifier (Check only one)



32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
900 CATON AVE, BACTIMORE,

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) Dec

Docks

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40528 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Month 23, Morris L. Pinacle Dec. 1999 7:36 AM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A VA Maryland Health Care System BALTIMORE 6. Sax 1 1 M 2 □ F 7. Aga (In yrs. last birthday) If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 25, 1931 5. Social Sacurity Number Birthplaca (State or Foreign Country) Months Days Hours 68 Yrs. MD 215-28-2501 Usual Rasidance of Dacedant 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Yes 2 No N/A Baltimore 10g. Citizan of What Country? 10e Street and Number 10f. Zip Code United States 3814 Granada Avenue 21207 . Was Decedent Ever In U,S. Armed Forces? TEI Yes 2 □ No If Yes, Giva Year or Dates: 52 - 53 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Naver Marriad 2 Married 1□ Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surname) Albraham E. Pinacle Rosa Tillery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mrs. Shirley M. Pinacle-Wife 1100 Bolton Street Apt. 914 Baltimore, MD 21201 20b. Place of Disposition (Name of cametery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Dec 28 1999 Owings Mills, MD Garrison Forest V.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Smith & Williams Funeral Home, P.A. Funeral Service Licensaa 2818 East Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Daath Immediate Cause (Final Urosepsis disease or condition resulting in death) Dua to (or as a consaquence of): Myocardial Infarction Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaase or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Acute Renal Failure Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Hypertension 24b. Were autopsy findings available prior to completion of ceuse of daath? 24a. Was an autopsy Necrotic Leg 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one)

Physician /Medical Examiner

Physician

' /Medical

Examiner

Funeral

Director

I ahow

Director MD

Funeral

þ

Completed

Be

2

Item 27 is marked other than "natural", or items 23s or 28s-f abov other traumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantel Hygiene. Important: If flem 27 is marked other than "natural", or its any findury or other traumatic event, the Monital Examities any filed the content of the Monital Examities.

with the Maryland

death v

Maryland 21215-0020

altimore,

P.O. Box 68760

Records,

Division of Vital

Examiner Physician/Medical g Completed Be P Certification:

law requires that the death certificate be executed physician and s the bunal-trans use as for use as ed by the a been signed by should be detac paga 2 certificata Attending Physician: funeral director. this After I or Attending efter deeth. Director: Aft

To the Hospital or Atte within 24 hours efter der To the Funeral Directo completely filled in by the

25. Was cese referred to medical axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Dinpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 1 DNatural 5 Panding Injury 1 Yes 2 No investigation 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Certifier 1 🖸 Certifying Physicien: To tha bast of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as statad. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29b. Signature and tiple of coalifier 29c. Licanse number 29d. Date signed (Month, Day, Year)

P12370

30. Name and address of person who completed causa of death (flore 23a) (Type Print)

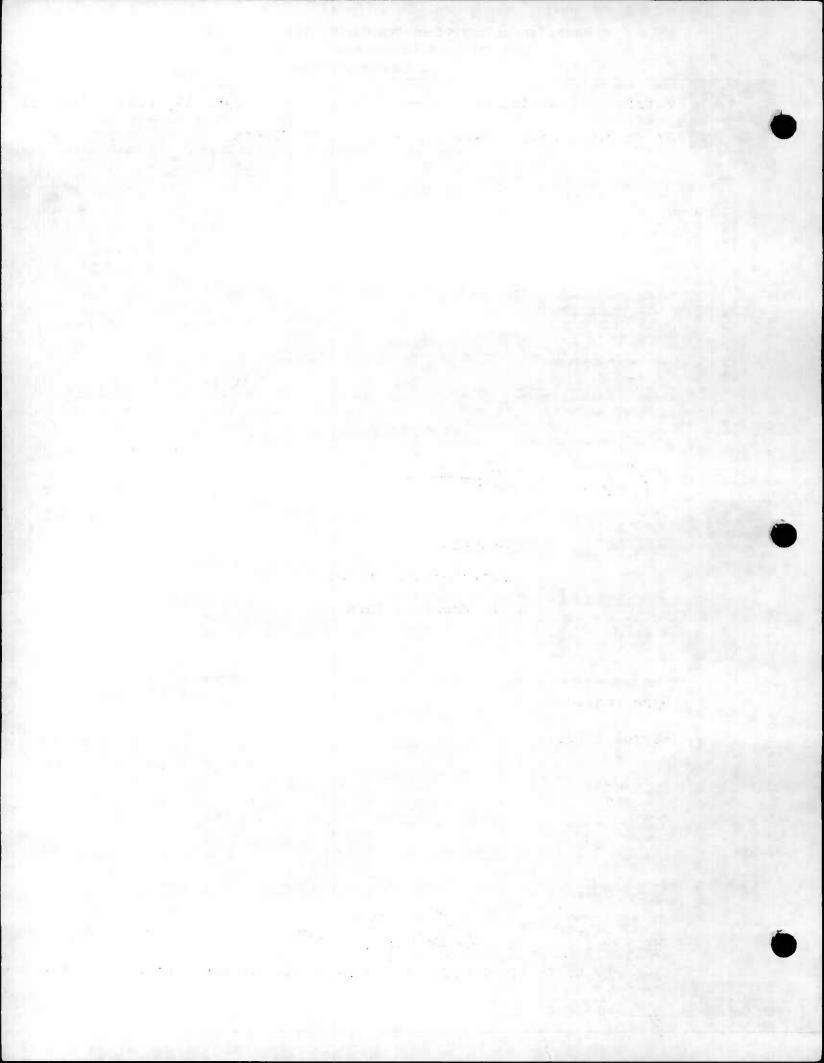
Baltimore, MD 21201 Bolling, /D., 10 North Greene Street, M Kimbérly L.

31. Date filed (Month, Day, Year) State Registrar

Medical

DEC 2 7

32. Registrar's Signature Poplar april

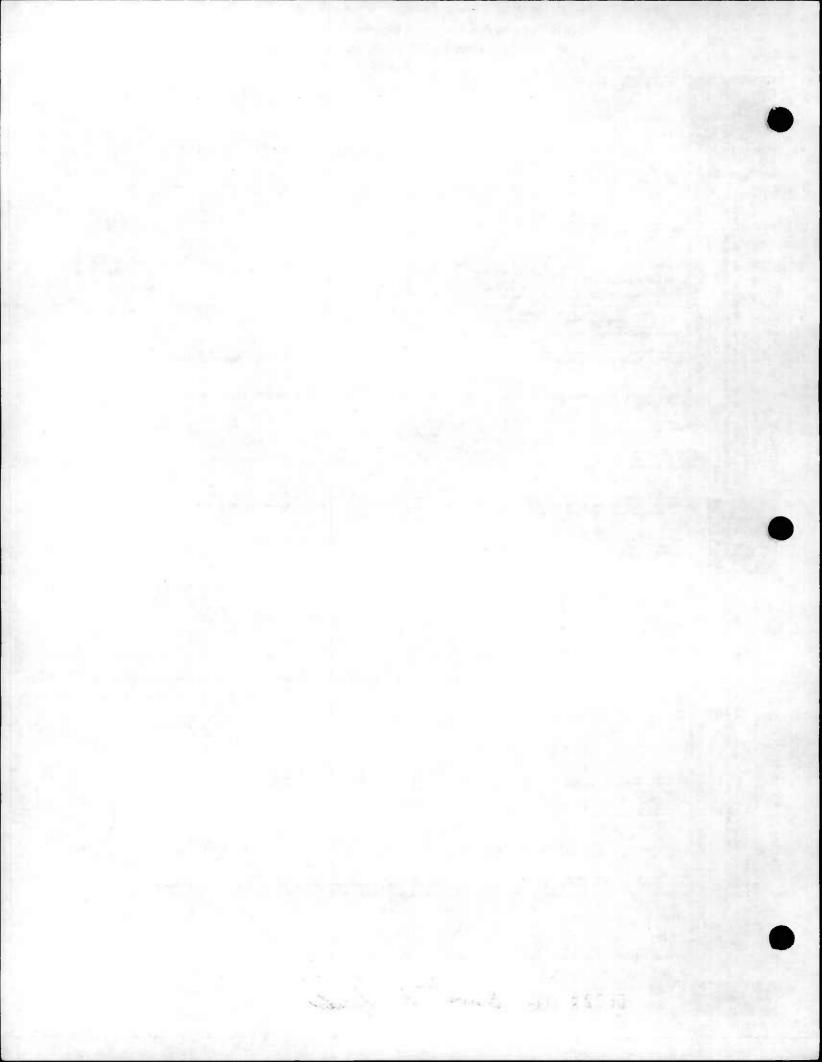


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician /Medical Examiner Funeral Director	4a Facility Name (If not institution	anne Lucil	1 - D				Month	Day	Year	
Examiner Funeral Director			re kres	sett			DEC	23, 199	9	1:10 A
Director	C 1 7 7 M					4b. City, Town, or L	ocation of Dea			
Director	5. Social Security Number	6 Hospice	e (In yrs. last birt	hday) If Un	der 1 Year	TOWSON	R Date of Bi		alti	
	219-32-2866 Usual Residence of Decedent	1□M NTE		rs. Monti		Hours Min.	8. Dete of Bi (Month, D NOV 1	7, 1936	Penns	ace (Stete or Foreign ry) y1vania
5 14	10e. State 10b. County		10c. City, Town			The Mark			10	d. Inside City Limits
be notified Director	MD N/A		Bal	timor	e					1. Yes 2 No
	109. Street and Number 1109 Scott St	treet		10f.	Zip Code 2123()	-71.0	10g. Citizen of W USA	het Count	ry?
Examiner must 5 by Funeral	11. Maritel Status 1 Never Married 2 Marri 3 Never Married 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 W If Yes, Give Year or Detes:			cedent of hipecify Cuba	tispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		- America c, White, e Whi	tc.
or than 'natura', the Medical S	15. Decedent (Specify only highes	s Education t grade completed)	16a.	Decedent's U	sual Occup work done	eation during most of world)	king	16b. Kind of Bu	siness/Indu	ustry
the M	Elementary/Secondary (0-12)	College (1-4or 5	1+)	ecret		<i>u</i>)		Trans	nort	ation
d other event, Be C	17. Father's Name (First, Middle, I	ast)		CCLCC	ary	18. Mother's Nam	ne (First, Middle	, Maiden Sumem		
affic ev	George	Crutchfiel	d			Fı	cances	Salmon		
1	19a, Informant's Name/Retationsh					and Number or Ru				
11 27 In 27	Douglas Ries	ett/son				Lane Pas			1122	
bent: If lies	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp	3 □Removal from State ecify)	20b. Place of cemeter, Metro	Cremat	ory,	Inc. 12/		Balti	more	, MD
Important in any in ance.	21. Signaturery Euneral Service & Morrow X Thomas Gr	Jugar		Crem 299	and Address	n Socie erick R	ty of d. Bal	Marylar timore,	nd, I	Inc. 21228
	23a. Pert1. Enter the disease, or shock, or heart failure. List	complications thet caused only one cause on each lin	the death. Do n	ot enter the n	node of dyir	ng, such es cardiac	or respiretory	arrest,		Approximete Interval Between Onset end Death
ysician Medical aminer	Immediate Ceuse (Final disease or condition resulting In deeth)	a. COLON C	CANCER Due to (or es e c	onsequence	of):		164 1 136			
physician and s the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	C.	Due to (or es e c	onsequence	of):		The state			
0 4	thet initiated events resulting in death) Last	d	Due to (or as a co	onsequence o	of):					
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ned by the attendin detached for use y Physician/N	Pert II. Other significant condition	s contributing to death bu	at not resulting in	the underlyin	g cause gn	en in Pert I.				the cause of death
2 should be								s an autopsy ormed?	con	re eutopsy findings ilable prior to apletion of cause eath?
page Corr							10	Yes 2∏ No	10	Yes 2□ No
Be Be	25. Was case referred to medical examiner?	Moneitel			l ou	26. Place of Dea	th (Check only	one)		
After this c funeral dire tion: To	1 Yes 2 No 27. Menner of Death 1 Naturel 5 Pending 2 Accident investig		y 28b. T		DOA Ott	4 LI Nursing H		how injury occurr		HOSPICE
with the Fundal Birector: After this completely filled in by the funeral Medical Certification: 1	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be Reas of Inju	ury - At home, far c. (Specify)		1			(Street end Number own, State)	er or Rurel	Route Number,
A Funeral pletely fille edical C		Physician: To the best of examiner: On the basis of and manner ste	examination end							
N S	29b. Signeture and title of certified				29c. Licens	e number		29d. Date signed	(Month, D	Dey, Year)
)	47-			Du	13725		12/	23/0	79
	30. Name and address of person v	who completed cause of de	eath (Item 23a) (Type, Print)		-			-(/	
	DR. TARIQ MAHM		JLANEY V		RD.	TIMONIUM	, MD 2	1093		

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Dec **Physician** Omelia :30a.M /Medical 4b. City, Town, or Location of Death Ac. County of D 4a Facility Name (If not institution, give street and number) Examiner Hospita more SIMON If Undar 24 Hrs. If Linder 1 Year 8. Data of Birth Month, Dey, 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign 5. Social Security Number **Funeral** Months Days 218-28-023 1 M 2 F Yrs. Sou Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23e or 28e-f show any july or other traumatic event, I'm Modical Experiment mainties and the modified at 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Dres 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Datas: 1 Naver Married 2 Married 1 Yes 2 No Saltimore, Maryland 21215-0020 Specify. þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT was retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Nemp (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 19b. Mailing Address (Street end Number or Aurel Route Number, City or Town, Stete, Zip Code) 4133 19a. Informant's Name/Reletionship (Type, Print) Rd, Randallstown COUSIN 20b. Place of Disposition (Neme cemetery, cremetory or other 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 212 MO. TMONE 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician Uterine CANCER Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequenca of) Physician/Medical Examiner ettending physician and for use as the bunel-trensit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): this certificate has been signed by the eral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably Completed by 24b. Were eutopsy findings available prior to complation of causa of deeth? 24e. Wes an eutopsy performed? 2 No 1 ☐ Yes 1 TYes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p Be 25. Was case refarred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 ER/Outpatient 2 1 Yes 1 Inpatient 3□ DOA 28c. Injury at Work? 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes To the Hospital or Atterwithin 24 hours effer ded To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner states. 29a. Certifier Medical 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Dev. Year) d cause of deeth (Item 23e) (Type, Print) BelvedereA 2434 6 32 Registrar's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rav 6/95

The was remarkably that the special street. The same the same the region [[] with the second Malagholt - letring Concer 123 26 J - 12 853 September on a partial section of 2434 to Balvedox Ru, to Inte 27218

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey **Physician** 95 12 Orin 10 /Medical 4c, County of Deeth 4e Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death Examiner B- 1 homore B- Inmove of Mary HOSP.F. If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthdey) **Funeral** Months 1 M 2 M N/A Mustend Director Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Madical Examinar must be notified at 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 □ No Director 10e. Street end Number 2328 Etting St 10f. Zip Code 10g. Citizen of Whet Country? 21217 21223 1936 W. Baltimore Street 2N Funeral USA 14. Raca - American Indien, 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus N/A Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify. Black. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) other than Elementary/Secondery (0-12) College (1-4or 5+) N/A N/A N/A N/A permit. Peges 1 and 2 should be filt. Department of Health and Mentel Hy Important: If item 27 is marked otherly injury or other traumatic event bine. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Willia M. Rogers unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21201 2328 Etting St Md. 21217 WILLA M. Rogers 22 S. Baltimore MD Balto. -UMMS Green St 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Remoyel from State ansdowne VIa land 21 Signature of Funeral Service tricenses Wade. 22. Name and Address of Facility Board 655 W. Baltimore Street Director Joseph, 21201 Joseph L Russ Funeral Home Baltimore, MD W. North Ave Balto. Md 21216 23a. Rart1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, snock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a conse nce of): Physician/Medical Examiner the attending physician and hed for use as the bunal-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Records, P.O. Box 68760, 8 To the Mospital or Attending Physician: The lew requires that the death certificate twithin 24 hours after death.

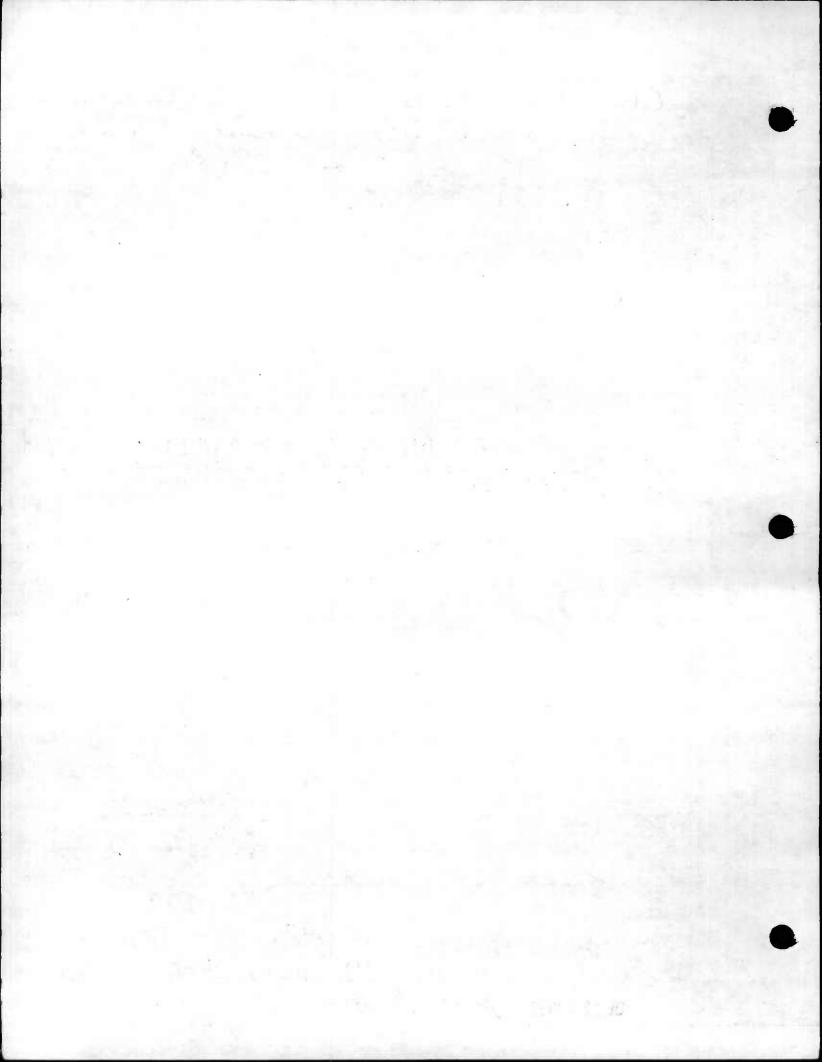
To the Funeral Director: After this certificate hes been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings eveileble prior to 24a. Wes en autopsy completion of cause of death? 1 Yes 2 TNO 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Waturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28l. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who eth (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

DEC 2 8 1999



FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)	La C				2. DATE OF GEATH		3. TIME OF OEATH
	VIRGINIA MAE R	ITTER					1999 YEA	5'50 04
	4. SOCIAL SECURITY NUMBER 5. S		n yrs. (ast birthday)	F UNDER † YEAR	IF UNDER 24 HRS.	Dec. 25,		10.03 P
		M 2 V F		ONTHE DAYS	HOURS MIN.	(Month, Day, Year)	Co	RTHPLACE (State or Foreign puntry)
					411/27	Oct. 30,19	15 Wes	st Virginia
8	9a. FACILITY NAME (If not institution, give street as	nd number)	9		OR LOCATION OF OR		9c. COUNTY O	F OEATH
e e	Future Care Old Cou	irt Nursing	Ceneter	Rand	allstown		Ral+	imore
5	RESIDENCE OF DECEDENT	TO ITAL STILL	OCHE CC				Daire	more
Ä	10a. STATE 10b. COUNTY			TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
5	MD Baltimo	re	Ra	ndalls1	town			1 YES 2 (X) NO
7	10s. STREET AND NUMBER			101	f. ZIP CODE		100 CITIZEN C	F WHAT COUNTRY?
R	2042 Coolidge Ave			1	21229			USA
빌	3642 Coolidge Ave.							
FUNERAL DIRECTOR	11. MARITAL STATUS 12. 1	WAS DECEOENT EVER IN FORCES? 1 TYES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No- 14. R	ACE — American Indian, lack, Whita, atc.
BY		F YES, GIVE WAR OR OA			2 NO Specify			pecify:
	^							White
<u> </u>	15. DECEOENT'S EDUCATION (Specify only highest grade complete)	N leted)	16e. DECEDENT'S US	UAL OCCUPATION OF THE PROPERTY	ON ost of working	tab. KIND OF BU	SINESS/INOUSTR	r
ių	Elementary/Secondary (0-12) Col	llege (1-4 or 5+)	(Give kind of worldife. Do NOT use r	etired.)				
P	8		Homema	ker		01	wn Home	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
	Lloyd Boyce				Grace !		,	
BE	19a. INFORMANT'S NAME (Type/Print)		T 405 MARINO 40	ADDEOD (OLL)				
2	1 11 - C W. I. C.					Route Number, City or Tow		
٠ ا	Rov Mason, Jr.					andallstow	n, MU	21229
	204. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal for	rom State	PLACE AND DATE OF	DISPOSITION (Ne	eme of	OATE 20c. LO	CATION — City or	Town, Stata
	4 Donation 5 Other (Specify)	Sh	enandoan	Memori	al Park	12/29/99	Winches	ter, VA
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E	,	22. NAME AI	ND ADORESS OF FA			
	120	Je /	44			11824	₹ Reiste	erstown Road
	James X	- un	u	ELINE	FUNERAL	HOME Reis	terstown	n, Md. 21136
9	23. PART I. Entar tha diseases, or comp	lications that caused	tha death. Do not	anter the mo	da of dying, auc	h as cerdlec or resp	ratory arrest,	Approximate
	ahock, or haert failure. List o	only one cause on ac	ch line.					interval Between Onset end Death
	disease or condition	1 to		1	1			Oliset end Death
- 1	resulting in death) a	Marie 14	CONSEQUENCE OF:	r yn	tare theor	`		vecup
		DOE TO (OH AS A	CONSEQUENCE OF):					
N	Sequentielly list conditions, b.	PSU	W/					
CERTIFICATION	if any, leeding to immediate	OUE TO (OR AS A	CONSEQUENCE OF):					
2	cause. Enter UNDERLYING CAUSE (Disease or injury							
E	thet initieted evente	DUE TO (OR AS A	CONSEQUENCE OF):					
ᇤᅵ	reaulting in deeth) LAST							
2								
4	PART II. Other aignificent conditione cor	stributing to death bu	t not reaulting in	the underlyin	g ceuse given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS
EDICAL	Delvic Trabay	chan to	ent;			1 YES 2		AWAILABLE PRIOR TO COMPLETION OF CAUSE
	Hu Date	00 - alie-				_ ' ' '		OF GEATH?
≥	Hy Po Thy		0.11100 000			/		1 YES 2 NO
PHYSICIAN: M	DID TOBACCO USE CON	AIKIROIF 10	CAUSE OF					
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:		26. PL	LACE OF DEATH (Ch	eck only one)		
S		Inpatient 2 - ER/Outpe			ne 5 🗆 Residenca	6 Other (Specify)		
Ĭ	27. MANNER OF GEATH	28a. OATE OF INJURY (Month, Day, Year)	26b. TIME C		JURY AT	28d. OEŞCRIBE HOW I	NJURY OCCURED	
	1 Netural 5 Pending	(Month, Day, Ibar)	INJUN		YES 2 NO			
B	2 Destates —	28a. PLACE OF INJURY	— At home, farm, atre	et, factory, offic		281. LOCATION (Street	and Number or But	ral Bruda Number
	4 Homicide Setermined	building, atc. (Speci	fy)	,,	·	City or Town, State)		ai riodio redificat,
[m]	204 CERTIFIER							
립	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the beat of my knowle	edge, death occurred	nt the time, date	and place, end due	to the cause(a) and mai	nner as stated.	
COMPLETED	One) 2 MEDICAL EXAMINER: On	the basis of examination	and/or investigation,	in my opinion, d	leath occured at the	time, date and place, an	d due to the ceus	e(a) and manner as atated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	Λ.	9		29ENLICENSE NUN			
B	Jan Stan	/ W	1		1580	75	171-	HED (Month, Day, Year)
၉	my o www	1 lago	N. W.		1-00	-1.	14	-1177.
	30. NAME AND ADDRESS OF PIERSON WHO COM	MPLETED CAUSE OF OEA	TH (ITEM 27) (Type, Pr	(m) - 00	0 1	711.0		
	10 James 1 mg	10.0	wines 1	Mill	1 Not.	4111/		
	31. DATE FILED (Month, Day, Year) DF C. 9 7 1999	32. REGISTRAR'S SIGNA	TURE		-			
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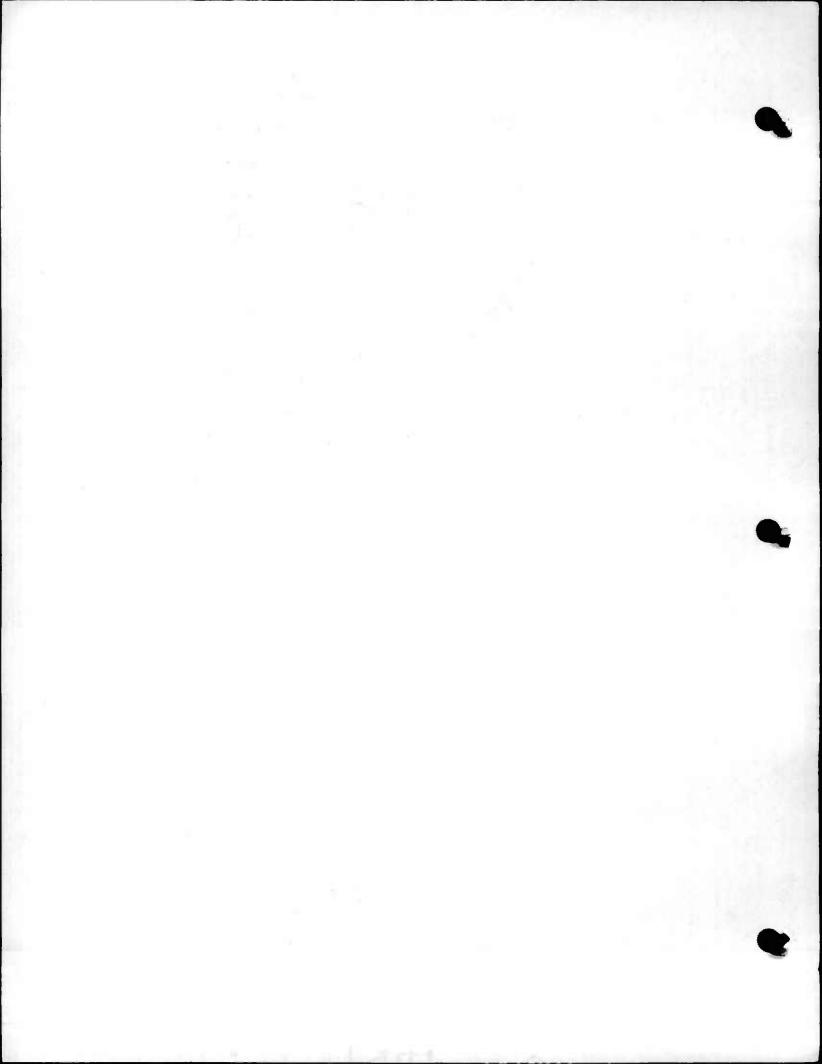
VILGINIA KILLER BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68780

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the foath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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EILEEN			Type or Pri		/ Depar		Health and	Mental Hyg			533	
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Maryla H show find at	MD MD	BALTIMOR	E	BALT	IMORE					1	1 ☐ Yes 2 No	
	MD 10e. Street and No. 3198 OI					10f. Zip Code	21208		10g. Citizen of Whet Count			
ther death v	11. Merital Status		12. Was Decedent	Ever in U,S.	13. Wa	as Decedent o	f Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Reca	- American In	dien,	
5-0020 72 hours after des natural, or items dical Examinar m		ried 2 Married 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No		Yes, specify C ☐ Yes 2 12 N		erto Rican, etc.)	Specify:	k, White, etc.	ITE	
2 ho	(0)	15. Decedent's Ed			16a. Decede	nt's Usual Oc	cupation	undring	16b. Kind of Bu	siness/Industr	y	
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D STEP	17. Father's Name	(First, Middle, Last) HER	RBERT	18. Mother's Neme (First, Middle, Maide BERT ROSENTHAL RHODA				Maiden Sumeme) CHIPMAN				
Maryle	19e. Informent's Name/Relationship (Type, Print) HERBERT ROSENTHAL / FATHER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, 2 3198 OLD POST DRIVE #11 — BALTIMORE, MD											
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E AU .		ficant conditions of	ontributing to death b	ut not resulti	t resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 U			
COTOS requires been sign should be								perform	e. Wes en eutopsy performed? , completion of deeth?		le prior to	
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= F # a (1 Yes 2 No 1 Yes 2 No							
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C St. St.	1 □ Netural 2 ☑ Accident 3 □ Suicide	5 ☐ Pending investigation 6 ☐ Could not be	(Month, Da	-Q4 1	Injury 13/AL	M 1	Yes 2 No	Driven 281. Location (St	over and Numb	Tw Cal	US in will	
DIVISION HOSPITAL OF ATTENDED OF ATTENDED OF THE PROPERTY OF T	4 ☐ Homicide	determined	building, et	ury - Al hom c. (Specify)		or, ractory, offic	20	City or Town	, State)	er or nurer no	CO - IW	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year)
DEC 2 8 1999

29b. Signature and title of certifie

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Dey, Year)

DECEMBER 21,1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM # 20a PER FH G778 12/28/99 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 22, J. 1999 9:40PM NORMAN RAYMAN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Deeth **Examiner** SUNRISE ASSISTED LIVING PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) NOV • 8,1910 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1X0 M 2□ F 216-03-4207 89 Yrs. MD Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 1 Yes 2 No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21208 3800 OLD COURT ROAD 'natural', or items 23a Funeral U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 11 Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Stetus e filed within 72 hours efter al Hygiene. other than "natural", or ite 1 Never Merried 2X Merried Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2 No Specify: P 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ENGRAVING Elamentery/Secondery (0-12) College (1-4or 5+) BUREAU OF PRINTING & PLATE PRINTER permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: if Item 27 is marked othe any Injury or other traumatic event ance. 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be (UNKNOWN) (UNKNOWN) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3418 MANOR HILL ROAD - BALTIMORE, MD 21208 DENNIS UHLFELDER / NEPHEW 20b. Plece of Disposition (Name of cemetery, cremetory or other) 20e. Method of Disposition 20c. Location - City or Town, Stete 4 N Surial 2 □ Cremetion 3 □ Removet from State 12/24/99 PIKESVILLE, MD DRUID RIDGE CEMETERY 4 □ Donation 5 Ø Other (Specify) ENTOMBMENT 21. Signetury of Funeral Service Licente 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximete tntervel Between Onset end Death 23a. Part1. Entar the diseesa, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner attending physician and for use as the burief-transit certificate be axacuted Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury Dua to (or as a consequance of): Box 68760. Physician/Medical thet initiated avents resulting In death) Last Due to (or es a consequence of) P.O. ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ De ed cate has been sig 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 No 1 Yes 2 No 1 Tyes of Vital I or Attending Physician: eftar deeth. Director: After this certifica director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) ASSISTED Hospitet: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) LIVING Certification: To 1 Yes 2 IN 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours e Funerel D 29e. Certifier Continying Physician: To the best of my knowledge, deeth occurred et tha tima, date end place, end due to the cause(s) end menner es stated. Medical completaly (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted. To the Within 2 To the

State Registrar

35 DEC 2 8 19

29b. Signature and title of pertilier

32. Registrer's Signeture

ua 30. Nemmand authoress of parson who completed cause of deeth (Item 23s) (Type, Print).

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

29c. License number

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runeral Director	10e. Street en	orest Lane	9			10f. Zip Code 2107	76		USA	of What Country	7
	11. Merital Sta		12. Wes Dec Armed Fo 1 Yes If Yes, Gi	2 ☑ No ve	If.	es Decedent of	Hispanic Origi ban, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No- 14. F	Race - American Black, White, etc.	
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		of Funerel Service Li		ula	22. Ha	Name and Add	ess of Fecility Funera	1 Home, I	.A.	1401	
	Immediate Ca									1 01	terval Between nset and Death
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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 50 - 99 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death NOTON BALTIMON CITY HAKBON If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day Year) 02/27/1906 5. Social Security Number 6 Sex Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months 10 M 200 Yrs. Puerto Rico 93 066-26-9048 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☑ Yas 2 ☐ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 1300 S. Ellwood Avenue 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ZXNo If Yas, Give 11. Marifal Status 1 Nevar Married 2 Married 1 ¥ Yas 2 □ No Specify: Puerto Rican Specify: Hispanic X5 Widowed 4 □ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) 5th Homemaker Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Unknown Castro Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Edward Rodriguez / Son 307 S. Washington Street Baltimore, Maryland 21231 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 12/24/99 Baltimore, Maryland Holy Rosary Cemetery 21. Signature of Funeral Service I 22. Nama and Addrass of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, of complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Lost only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uss copyribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 2 TONG 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medicel examinar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 20 No 1 Yas 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manny of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? T ENatural

tha death certificate be executed burial-tran physician s the burial Box 68760. P.O. signed b Records, pega 2 certificate Division of Vital or Attending Physician: this

Examiner After deeth. To the Hospital or Attendi within 24 hours after deeth. To the Funerel Director: A completely filled in by the fi

Physician

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Director

Funerai

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death

permit. Pages 1 and 2 should be filled within 72 hours affer c Department of Heelih and Mental Hygiene. Introcramt: if Nem 27 is marked other than "inturel", or them pages in the manual cevent, the manual pages.

Physician

/Medical Examiner

Saltimore, Maryland 21215-0020

Physician/Medical p Completed Be Certification: To

Medical

29a. Cartifia

29b. Signati

2 Accident

3 Suicide

4 Homicide

Z certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to the ceuse(s) and mannar as stated.

5 Pending investigation 6 ☐ Could not be

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29d. Dafa signed (Month, Day, Year)

mplated causa of daath (Itam 23a) (Typa, Print)

30. Nama and addrass of person AGLIATELLI

31. Data filed (Month, Day, Year) DEC 2 8 1999 32. Registrar's Signatura

State Registrar

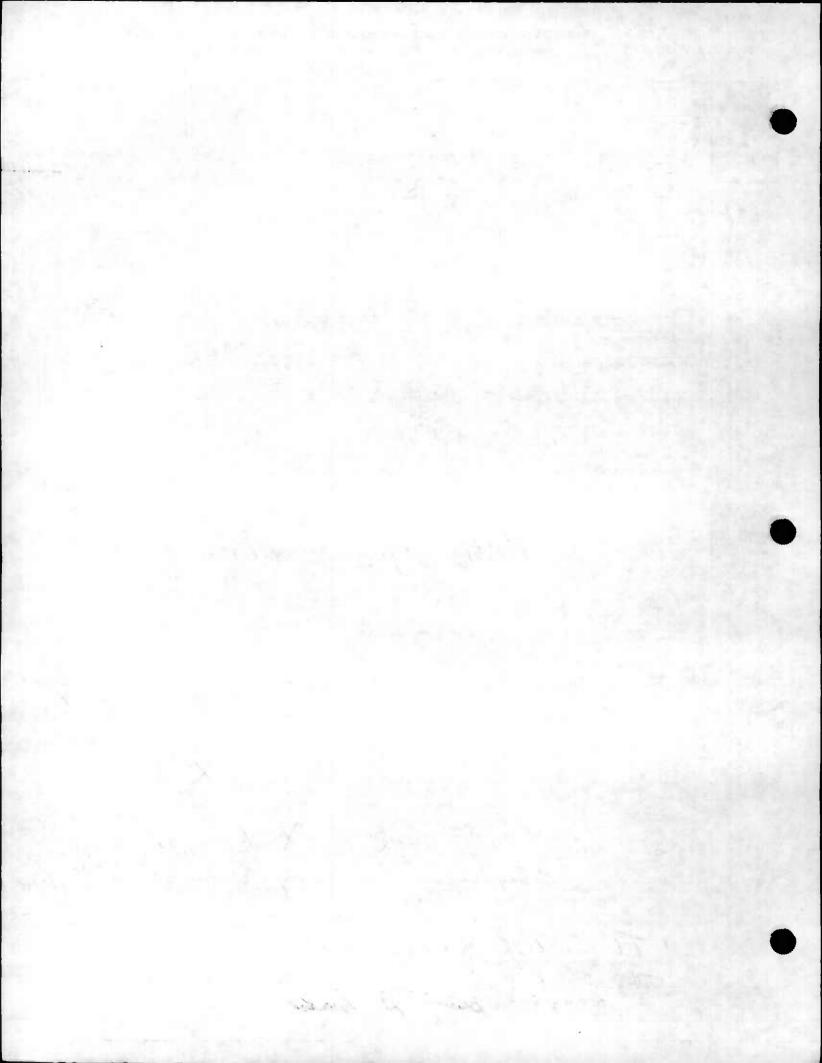
DHMH 16 Rsv 6/95

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland	Department of Health and Mental Hygi	en

## Facility Name (if not institution, give street and number) Anne Arunde I Medical Center 10	99 02:21 PM seeth rundel Sirthplaca (Stata or Foreign aryland 10d. Insida City Limits 1 Yas 2 X No Country? marican Indian, hita, atc. White ss/Industry			
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William Sorensen 19a. Informant's Name/Ratationship (Type, Print) Nayoma Y. Sorensen/wife 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Metro Crematory, Inc. 12/27/99 21. Signatura of Fungral Service Licensea Cremation Society of Maryland Dawn F. McDonald 299 Frederick Road Baltimore 23a. Part1. Enter tha disaesa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Baltimore 25c. Name and Address of Facility. Cremation Society of Maryland 299 Frederick Road Baltimore 23a. Part1. Enter tha disaesa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Due to (or as a consequence of): any, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury) Cause (Diseasa or injury) The cause (Diseasa or injury) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa givan in Part I. 23b. Did tobsecco use contributing to deeth but not resulting in the underlying causa givan in Part I. 23b. Did tobsecco use contributing to deeth but not resulting in the underlying causa givan in Part I.				
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Sequentially list conditions if any, leeding to immediate cause. Entar Underlying that pillated avants properly and the property of the prop	ty, MD 21042			
A Donation Solitar (Specify) Metro Crematory, Inc. 12/27/99 Baltimos				
Physician /Medical Examiner Page 1 Sequentially list conditions in a consequence of list and the list of light of the l				
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t se ge g				
the position of the position o	ute to the cause of death?			
24e. Was en autopsy parformed?	· · · · · · · · · · · · · · · · · · ·			
N S S S S S S S S S S S S S S S S S S S	b. Ware autopsy findings available prior to complation of cause of death?			
Sel s	1 No 2□ No			
25. Was casa referred to medical axaminar? 1 X Yes 2 No 25. Was casa referred to medical axaminar? 1 X Yes 2 No Check only ona) Check only ona) Check only ona)				
1 Inpatiant 2 XER/Outpatient 3 DOA 4 Nursing Homa 5 Rasidence 6 LiOthar (5				
27. Mennar of Death 1 Natural 5 Pending Invastigation 28a. Dete of Injury 28b. Tima of Injury at Work? 1 Natural 5 Pending Invastigation 28b. Tima of Injury at Work? 1 Yes 2 No 5 Pending Invastigation 1 Yes 2 No 5 Pending Invastigation 1 Not the Pending In	regret entre			
2 Accident Invastigation 1/23/99 130 HR M 1 Yes 2 No 1 Yes 2 N	hile			
building, etc. (Specify)	Purol Divisa Number			
29a. Cartifliar Quantifliar To (na best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner	Rurel Route Number,			
29b. Signatura and title of cartiflar 29d. Data signad (M	Judge in			
	as stated. due to the cause(s)			
30. Name and address of person who completed cause of that (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Marylane	as stated. due to the cause(s) onth, Day, Year)			
State Registrar State Registrar State Registrar	as stated due to the cause(s) onth, Day, Year) 24, 1999			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 405 AMEND#5 PER INFMNT. G779 1-6-2000 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death SPELSRER Yee **Physician** WALTER DEC 23 1999 4:55 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Genesis Eldercare/Spa Creek Center Annapolis Anne Arundel 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. Birthplace (Stete or Foreign Country) 5. Sociel Security Number 8. Date of Birth (Month, Dey, Yeer) **Funeral** 2435-147865565 Usuel Residence of Decedent Yrs. Director DEC 7, 1919 West Virginia death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Marial Hygiene. Importment: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1 Yes 2 No MD Anne Arundel Annapolis Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1117 Mitchell Street 21403 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 □ NdW W II IfYes, Give Year or Dates: 11. Maritel Status Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White g 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Obstectrics/ Elementary/Secondary (0-12) College (1-4or 5+) Gynecology Medical Doctor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Charles Augusta Spelsberg Kathleen Pearl Leonard 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1117 Mitchell Street Carol Lewnes/daughter Annapolis, MD 21403 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetlon 3 ☐ Removel from State Metro Crematory, Inc. 12/24/99 | Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Cremation Society of Maryland, Inc. Iroma Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) P.O. Box 68760 that initieted events resulting in deeth) Lest Due to (or as e consequence of) ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en autopsy peen page 2 s certificate has 1 Yes 2 ₩NO 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Wes case referred to medicel exeminer? director Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending 1 ANaturel death. 1 Yes 2 No investigation 2 Accident after death To the Hospital or Atter within 24 hours after der To the Funeral Oirecto completely filled in by th 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) edical 29a. Certifier (Check only one) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar **DHMH 16 Rev 6/95**

30. Name end eddress of

31. Dete filed (Month, Pay, Yes

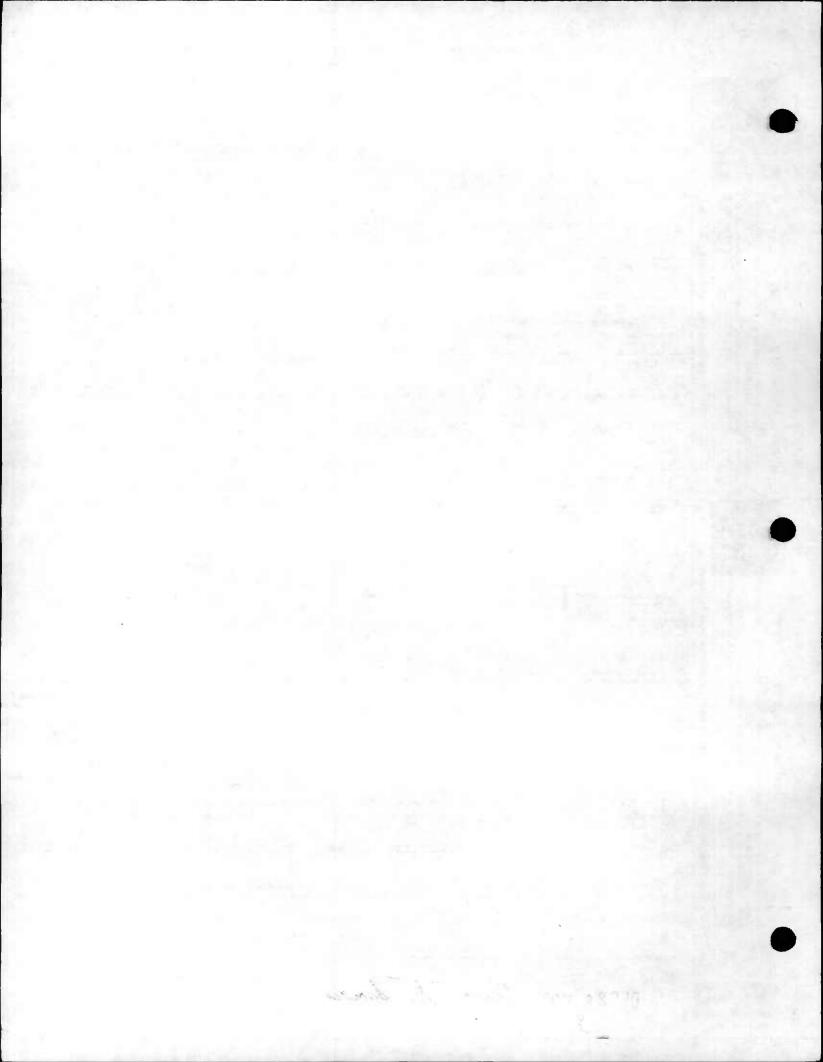
23e) (Type, Print)

32. Registrar's Signeture

Physi /Med Exam

ian	1. Decedent's Name (First, Middle, La				1	2. Date of Deat Month		3. Time of Death			
cal	K1e	DEC 22, 1999 8:10									
ner	4a Facility Name (If not institution, giv Stella Maris				4b. City, Town, or I		4c. County of Bal	timore			
ı	5. Social Security Number 6. S	*	(In yrs. last bit	thday) If Under 1 Yours. Months De). Birthplace (Stata or Foraig Country) Germany			
	Usual Residence of Decedent	**				rib 0,	1/2/	JC Linearly			
	10a. State 10b. County	Date Hill	10c. City, Tow	norLocation kesville				10d. Inside City Limits			
	MD Baltim	ore				1 □ Yes 2√ No					
	1307 Church H	ill Drive		10f. Zip Cod	21208	at Country?					
	11. Maritel Status	12. Was Decedent E	ver in U.S.		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-		American Indian,			
	1 Never Married Merried	Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		If Yes, specify 0		o Rican, atc.)	Black, White, etc. Specify: White				
	15. Decedent's Ed	ducation	16a.	Decedent's Usuat Oc	cupation	47	16b. Kind of Bush	nass/industry			
	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	-)		one during most of wor tired)	king					
ŀ	12		H	lomemaker		400	Own H				
2 2 8 - 4 (Usual Residence 10a. State MD 10e. Street and N 1 3 0 7 (11. Maritel Status 1 Never Ma 3 Widowed (Sp Elementary/Sp 12. 17. Father's Name 19a. Informant's Danjel 20a. Mathod of D 1 Burial 4 Donation 21. Signeture of A Immediata Causa disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease that initiated ever resulting in death	17. Father's Name (First, Middle, Last, Klemens					eszenz I					
	19a. Informant's Name/Relationship (Daniel Schille				reet and Number or Ru Ch Hill I						
	20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place o cemete Metro	f Disposition (Name or ry, crematory or other Cremator	place) y, Inc. 12		20c. Location - Ci Baltim	ore, MD			
	21. Signeture of Funeral Service Uses Thomas Greg	ujor		22 Name and A	drass of Facility Cie 10n 50cie ederick F	ety of I					
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haarf failura. List only one causa on aach lina. Approximate Interval Batween										
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as a	consequence of):							
Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):											
	Part II. Other significant conditions of	contributing to death but	not resulting i	n the underlying ceuse	given in Part t.	23b. Did to	bacco use contr	ibute to the cause of death			
1						1 🗆 Y	es 2□No 3	Probably William			
						24a. Was a perform		24b. Wera autopsy findings available prior to completion of cause of death?			
•						1 🗆 Ye	es 2XI No	1 Yes 2 No			
•							a)				
a completed by	25. Was casa refarred to medical examiner?	Hospital:			Other	th (Check only on					
	examiner? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pending	Hospital: 1 Inpatien 28a. Date of Injung (Month, Day	285.	Tima of 28c.	Other: 4 Nursing H	ome 5 Reside		(Specify) HOSPICE			
	examiner? 1 Yes 2 No 27. Mannar of Death	28a. Date of Injury (Month, Day	Year) 28b.	Tima of 28c.	Other: 4 Nursing H Injury at Work? 1 Yes 2 No	ome 5 Reside 28d. Describe ho	enca 6 X Other ow injury occurred				
cel unication. To be completed by	examiner? 1 Yes 2 No 27. Mannar of Death 1 Naturai 5 Pending investigation 3 Suicide 6 Could not b datarmined 29a. Certifier 1 Certifying Ph	28a. Date of Injury (Month, Day	y - At homa, fa (Specify) my knowledge examination an	Tima of njury M 28c. Imm, street, factory, off	Other: 4 Nursing H Injury at Work? 1 Yes 2 No ice	ome 5 Reside 28d. Describe ho 28f. Location (Si City or Town	onca 6 X Other ow injury occurred and Number o, State)	or Rural Route Number,			
	examiner? 27. Mannar of Death 1 XNaturai 5 Pending investigation 3 Suicide 6 Could not b datarmined 29a. Certifier (Check only 2 Medicat Exam	28a. Date of Injury (Month, Day 28a. Place of Injury building, etc. 28a. Place of Injury building, etc.	y - At homa, fa (Specify) my knowledge examination an	Tima of njury M 28c. M Imm, street, factory, off Indian occurred at the door invastigation, in r 29c. Lice	Other: 4 Nursing H injury at Work? 1 Yes 2 No ice e tima, date and place ny opinion, daath occur cense number	ome 5 Reside 28d. Describe ho 28f. Location (SI City or Town , and due to the corred at tha time, di	onca 6 X Other ow injury occurred and Number (, State) ause(s) and mannate and placa, a	or Rural Route Number,			
Medical Certification: To Be Completed by P	examiner? 1 Yes 2 No 27. Mannar of Death 1 Naturai 5 Pending Investigation 3 Suicide 6 Could not b datarmined 29a. Certifier (Check only one) 29b. Signeture and life of certifor	28a. Date of Injury (Month, Day 28a. Place of Injury building, etc. 28a. Place of Injury building, etc. 28a. Place of Injury building, etc.	Year) 28b. I	Tima of njury M 28c. M Imm, street, factory, off In, daath occurred at the d/or invastigation, in r 29c. Lic.	Other: 4 Nursing H Injury at Work? 1 Yes 2 No ice e tima, date and place ny opinion, daath occu	ome 5 Reside 28d. Describe ho 28f. Location (SI City or Town , and due to the corred at tha time, di	onca 6 X Other ow injury occurred and Number (, State) ause(s) and mannate and placa, a	or Rural Route Number, her as stated. d due to the causa(s) (Month, Day, Year)			

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Year Month **Physician** 22, 1999 09:45 AM DECEMBER MARY D. SCHULTE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days 10 M 20 F Yrs. 217-24-5806 Usual Residence of Decedent Director JUNE 2, 1927 MD 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director BALTIMORE HYDES MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 13705 ECK CAOS 21082 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stalus 1 Yes 2 No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married ö 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **CETIUN** Elementary/Secondary (0-12) College (1-4or 5+) UNITED CONTAINER MACHINERY CONTAINER MACHINERY 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of hand Mental F 8 Pages 1 and 2 should be RAYMOND J. DALTON MARY FRANCES KEUY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of Health of Hea LONG (PREEN RD. COLD ARM MD 21C on (Name of Date 20c. Location - City or Town, State 21057 DOROTHY DALTON, DANGHTER 4712 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 8 Department of Important: If It any injury or o DEC 24 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HIGHVIEW MEM. GONS. 1999 FALLSTON, MD 22. Name and Address of Facility EVAN'S FUNDEAL CHAPEL 21. Signature of Funeral Service Licenses anni 8800 HARFORD PD. PARKVILLE, MO. 21234 Enter the disease, or Approximale Interval Between Onsel end Dealh on mal caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical CARDIOMYOPATHY 1 1/2YRS Examiner Due to (or as a consequence of) Physician/Medical Examiner 6 MONTHS COLON CANCER attending physician and for use as the bunal-trensit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Box 68760. 4 DAYS ACUTE RENAL FAILURE Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TRICUSPID VALVE INSUFFICIENCY Records, Š 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy CHRONIC OBSTRUCTIVE PULMONARY DISEASE page 2 1□ Yes 2□ No 1 ☐ Yes 2 No certificate Vital Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpalient 3 DOA of this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Attending 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completaly filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signature and title of certifier? 29c. License number 29d. Date signed (Month, Day, Year) 12-23-7 D48271 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year)

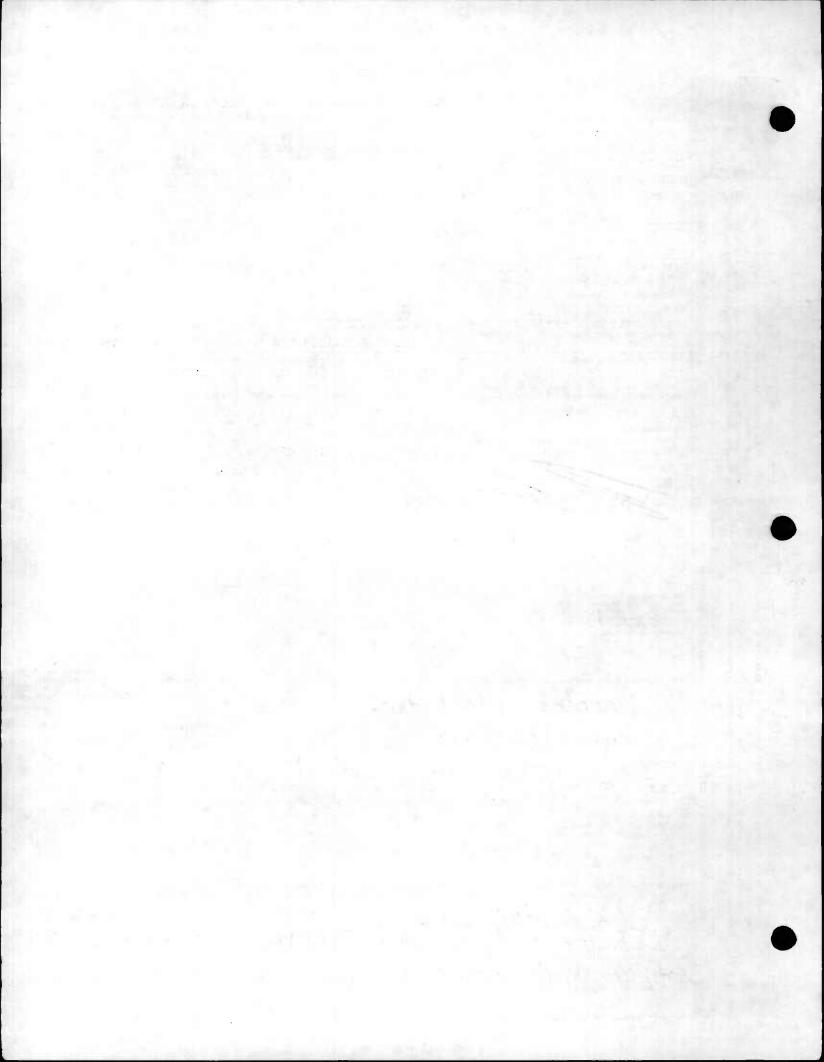
DEC 2 8 1999

FAHED KOULI, M.D., 7600 OSLER DRIVE, S-203, TOWSON, MARYLAND 21204

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day **Physician** ROBERT OWEN SCHULTZ, **DECEMBER 23, 1999** 3:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Yeer | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 1₽ M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 217-30-3266 65 Yrs. Director NOVEMBER 23, 1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show GLEN BURNIE 1 Tyes 2 1 No Director MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 809 GEIS CIRCLE 21061 ILS.A. Nerna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Meritel Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental hygiene. Important: If itam 27 is marked other than "natural", or iten any injury or other traumatic avant, the Medical Exertines 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CRANE OPERATOR BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM LEE SCHULTZ MAMIE LOUISE SOURS 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. BETTY SCHULTZ 809 GEIS CIRCLE, GLEN BURNIE, MD. 21061 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 12/27/99 1 ☐ Burial 2√ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER, LLC STEVENSVILLE, MD. 21. Signature of Funeral Service 22. Name end Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GELN BURNIE, MD. 21061 Approximete Intervel Between Onset and Death 23a, Part 1 15 he disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, there is the control of the cause on each line. **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical ear Examiner Due to (or es e consequence of) Physician/Medical Examiner slcian and burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequença of): physician s the burial 68760. Due to (or as a consequence of): Box law requires that the death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 DINO 1 ☐ Yes 2 No VQ. Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? 86 26. Plece of Death (Check only one) Hospitel: 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Netural death. ne Hospital or Attandi n 24 hours after death. ne Funeral Director: // pletsty filled in by the f 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner es stated. Medical completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only one) within 2 \$ Pasident 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) Chief 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Satinder to 31. Date fled (Month, Day, Year) Street Baltimore Hanover South

State Registrar 32. Registrer's Signature

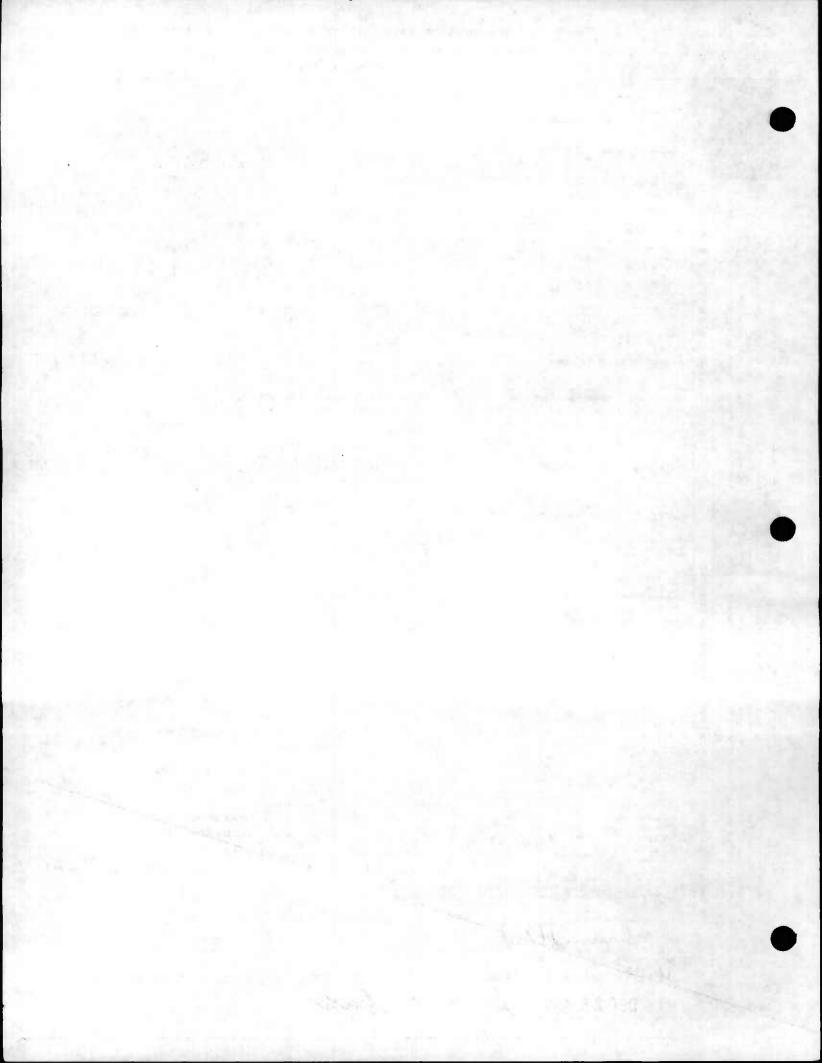


Rose Bessie Scherr

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

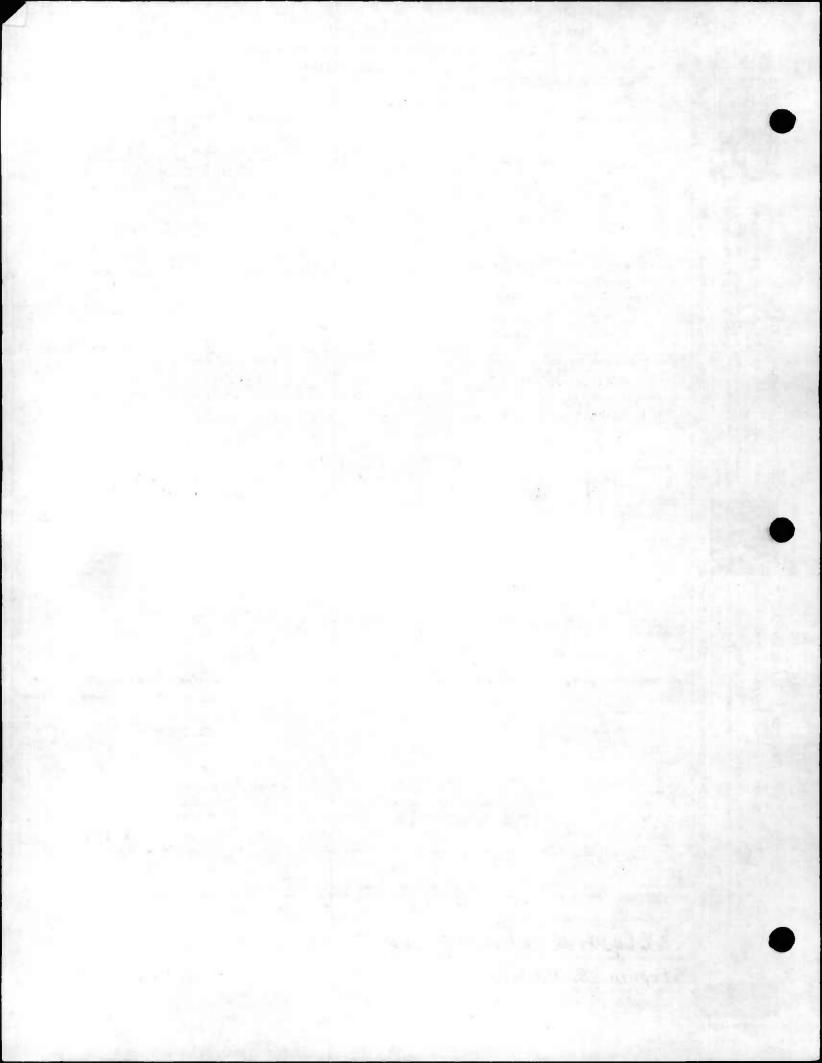
State of Maryland / Department of Health and Mental Hygiene 99 40512

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uneral irector	5. Social Security Number 6. 217–18–5945	Sex 7. A	7. Age (In yrs. lest birthdey) If Under Months				Year If Under 24 Hrs. B. Date of Birth Min. AUG.			irth 13, 1923 9. Birthplece (State or For Country) MD		
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by d	11. Meritel Status 1 Never Merried 2 Married \$ Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Yeer or Detes:	7	if Yes, s	cedent of H pecify Cube 2 No	an, Mexican,	n? (Specify Y Puerto Rican	'es or No- , etc.)	or No- Bleck, White, Specify:			
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completely filled Medical Ce	29e. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and menner st	of my knowledge of examination ar	e, death occurre	ed at the tir on, in my o	ne, date and pinion, death	place, and du	W. Bewe ue to the cau the time, dete	se(s) end me	enner es s	tated.	
Comp	29b. Signeture and title of certifier	1 Chrosen			29c. Licens	e number			Date signe			
State Registrar	30. Name and eddress of person was 31. Dete filed (Month, Day, Year) DFC 2. 8. 190	huteno 32. Apogisti	deeth (item 23a) rar's Signature	111 Per	nn St		Baltim	ore, M	Maryla	nd 21	201	



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DOUGLAS SCHAEFER	AMEND ITEMS: #		nd / Departr 27, <i>Certifi</i>	nent of l	lealth ai			40543
Physician			1			Month	Dey	Year
/Medical Examiner			chaerer_		4b. City. Town			
Examiner	ST.JOSEPH HOSPI							
Funeral								
Director	212-72-8940 Usual Rasidance of Decedent	July 15	, 1958	Baltimore				
filed within 72 hours after death with the Maryland hyglene. ther than "natural", or items 23a or 28a-f show out, the Wedical Examinet must be confied at a Completed by Funeral Director	10a. Stata 10b. County	10c. Cit	ty, Town or Localio	n				10d. Inside City Limits
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Be C	17. Fathar's Name (First, Middla, Last		LICCLIO	11103 1				
To B	Ronald John Schae	fer			Ruth	Christine	Potter	
	19e. Informant's Name/Relationship (19b. Mailing Ad	idress (Street				tete, Zip Code)
5	Ruth C. Schaefer/	Mother	2106	Old Pi	ne Roa	d Timoniu	m. MD 210	193
e e	20a. Mathod ol Disposition	Dues do constituent of the process of numbers and numbers and process of the pro						
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyghere. Important: if item 27 is marked other than any injury or other traumatic event, trail and the contract. To Be Compiled.	4 Donation 5 Other (Special	Bal Cre	timore W	ashing	ton		Laur	rel. MD
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o as the burial-transit Medical Examiner	Immediate Causa (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leeding to immediate causa. Entar Undarkying Cause (Disease or Injury that initiated events rasulting in death) Last	b. Due to (o	or es a consequenc	e of):	XICAT	ION		
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Y P							THE ZUCT NO 3	SECTIONS 4 Unknown
Completed by		Due to (or as a consequence of):						
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led in by the funera Certification:		28a. Data of tnjury (Month, Day Year)	Injury					
cati	Z La Moordanii				Yas 2 No			
Ti-	4 Homicide datarmined	building, etc. (Specify	v)			City or Toy	street end Number yn, State) LV NIOT,7NI	or Hural Houte Number,
edical Co	29a. Cartifiar 1 ☐ Certifying Ph	ysician: To the best of my know	wiedge, death occi	urred at the tir	ma, data and projects	plece, and dua to tha	cause(s) end mann	nar es stated.
completely filled in by the funeral director, page Medical Certification: To Be Com	one)	and menner steted.						
8	29b. Signature and little of certifier	. 1		29C. Licens	se number		290. Data signed ((Month, Day, Year)
	aysys	Vada	MP		M.E.		DECEMBER	21,1999
		completed causa of death (Hem 2 adent Z 32. Registrar's Signa			Street	, Baltimor	e, Maryl	and 21201
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #19a PER FH GZZ8 12/28/99 AH Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3 Time of Death Month Dev **Physician** :20 DECEMBER 22,1999 1m,0 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner aris te Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 10M 201 Months Days Hours 25-38555 Yrs Director 6 1001010 Usual Residence of Decedent State 10b. County 10c. City, Town or Location 10d. Inside City Limits 108 23a or 28a-f show the Medical Examiner must be notified at 1-BYes 2 No Director N timore 10f. Zip Code 10g. Citizen of What Country? 10a Street and Number Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. or items 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 'natural', 3 ₩idowed 4 Divorced ac permit. Pages 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, eny injury or other traumatic event, the lateral once. Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coltege (1-4or 5+) salto. Lita CLIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 0,1 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 705 earse Lane 01-12010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) arulco re.MCTON 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Herre & P eller Bricalua N. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervet Between Onset end Death **Physician** Immediate Ceuse (Finet disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner nding physician and use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760. that initieted events resulting in death) Last Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, á 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: director, AT MERCY 25. Was case referred to medical 26. Place of Death (Check only one) STE //A MARIS Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS DICE Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 this 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Direcompletely filled in b

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature end title of certifie

31. Dete filed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (ttem 23a) (Type, Print)

1999

30

32. Registrer's Signeture

RISEBERG

DEC 28

DHMH 16 Rev 6/95

49 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) end manner steted.

29c. License number

29d. Date signed (Month, Day, Year)

BAHI MORE

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician December 19, 1999 William B Stonesifer 10:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2525 Paper Mill Road Baltimore Phoeni x If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1₽M 2□F 215-07-9736 Yrs Director Sept. 9, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2√ No Maryland Phoenix Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Paper Mill Road 21131 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after XX Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Maryland 21215-0020 Specify: White 1 Yes 2√ No Specify: 31 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City and Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Teacher 12 yrs. 6 yrs. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Stonesifer Goldie Shubkagel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Betty Lou Shubkagel (Cousin) 1013 Omar Drive Crownsville, Maryland 21032 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Upper Cross Rds. Cem. December 22, 1999 Harford Co., Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Neme and Address of Fecility Lassahn Füheral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. I Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cardio-Renz Examiner Due to (or as a consequence of) Examiner SCUlar inding physician and use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): signed by the at I be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à Completed 24b. Were autopsy findings evailable prior to completion of cause ot death? 24a. Wes an autopsy performed? page 2 i hea certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Attending Physician: director. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b, Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending Within 24 hours after death: Within 24 hours after descriptor: After To the Funeral Director: After Contract and the furnity and 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type Prot) 1 /e 7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacks DEC 2 8 1999 Registrar

Please Type or Print in Black Indeiible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth DECEMBER 22 **Physician** SINGH 1999 SITA 11:50 a.m /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) Sept. 12,1942 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Days Hours Yrs. Director 365-72-1461 Usuel Residence of Decedent India 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Fairfax Herndon 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 12019 Cheviot Drive 20170-2702 must b USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status filed within 72 hours after 1 Never Merried 2 Merried Specify: Asian Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be tild. Department of Health and Merital Hy Important: if Nem 27 is merited ofth any Injury or other traumetic event about 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Shri Radhe Shyam Singh Savitri Singh 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dr. Dharm Vir Singh -Husband 12019 Cheviot Drive Herndon, VA 20170 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 第 Removel from State 4 Donetion 5 Other (Specify) 12/28/99 Patna, India Crematory in India 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Green Funeral Home, Inc. 721 Elden Street Herndon, VA 20170 23a. Part1. Enter the disease, or coefficiations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 18 HOURS MASSIVE INTRAPARENCHYMAL BRAIN HEMATOMA Examiner Due to (or as e consequence of): Physician/Medicai Examiner THROMBOCYTOPENIA 8 DAYS sician end burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): ALLOGENIC BONE MARROW TRANSPLANTATION 8 DAYS P.O. Box 68760. that initiated events resulting in deeth) Last Due to (or as a consequence of) 18 MONTHS ACUTE MYELOID LEUKEMIA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NEUTROPENIC FEVER à Records. Sign 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed VENOCCLUSSIVE DISEASE 24a. Wes en eutopsy performed? 2 0 No 1 Yes 2 No Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Certification: To 1 Yes 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Division of this funeral 27. Menner of Death 1 Neturel 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fur 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medicai Kcritifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) end manner steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier DECEMBER 22, 1999 RES-000 30. Name and eddress of person and completed cause of death (Item 23a) (Type, Print) VALLA DARES 32. Registrer's Signature outs Registrar

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of He'alth and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death DECEMBER 23, 1999 **Physician** 1:45 AM TAMULONIS WILLIAM H /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yrs. Director 215-14-0797 MD DEC. 11,1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits t than "natural", or items 23a or 28a-f ahor the Madical Examiner must be notified at 1 Yes 2 10 Director MD BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? # D 2915 CONROY 21234 V.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: f Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 is marked other than " ir traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) PRESSEODM SUPERINTENDANT NEWS AMERICAN Baitimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) B TAMULONIS ANDREW MARGARET BYENE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LORRAINE TAMULONIS, SPOUSE PARKVILLE, MD. 21234 20c. Location - City or Town, State CONROY CT. 2915 # D 20b. Plece of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State DEC. 27. 4 ☐ Donetion 5 ☐ Other (Specify) 1999 PARKVILLE, MD PARKWOOD COMETERY 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21. Signature of Funerel Service Licensee ason 8800 HARFORD RD. PARKVILLE, MD. 21234 afters that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) PNEUMONIA /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner use as the buriel-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) Box 68760 that initiated events resulting in death) Last Due to (or es a consequence of) ed by the e P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown s been signed to should be det CONGESTIVE HEART FAILURE Records, þ Completed 24b. Were autopsy tindings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 Yes 2 No certificate of Vital Attending Physician: director. Be 25. Wes case referred to medicaf 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After this funaral d 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c, fnjury at Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1) Netural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Tyes 2 TNo 2 Accident 6 Could not be 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of person who completed cause of death (florm 23a) (Type, Print)
BOON P. LIM, M. D., 7601 OSLER DRIVE,

31. Date filed (Month, Day, Year)

DEC 2 8 1999

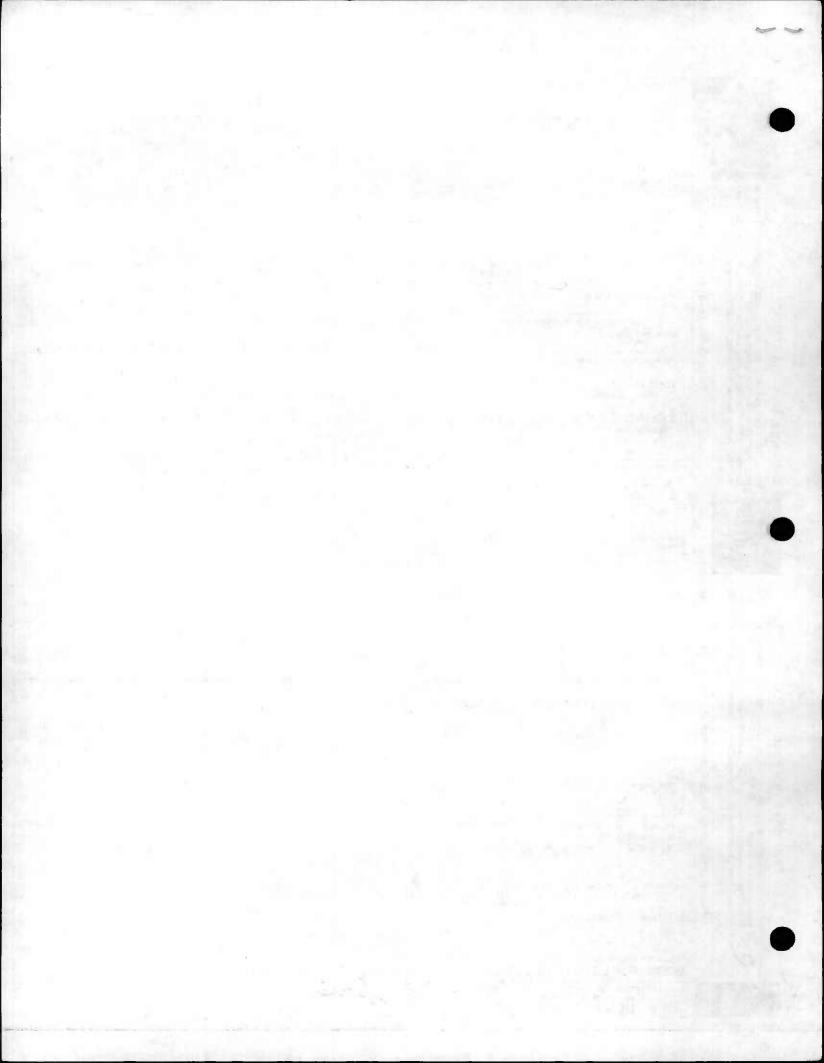
32. Registrar's Signature

D37254

TOWSON, MARYLAND

12-23-99

21204



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TARRICONE Month 5551E Dec 3 10 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Data of Birth (Month, Day, Year) JUNE 24, 1928 9. Birthplaca (Stata or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days 71 Vrs 234-40-4090 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnsida City Limits 28a-f ahow 1 ☐ Yes 2 ☐ No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or itsms 23s or 8528 Timberland Circle 21043 USA 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. Hygiene. Hygiene. ther then "netural", or its 1 Yes 2 No
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Yeer or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic eve Greenway Christian Cora Lee Richards 19e. Informent's Name/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrice Kalench - daughter 8528 Timberland Circle, Ellicott City, Md. 21043 20e. Method of Dispersion

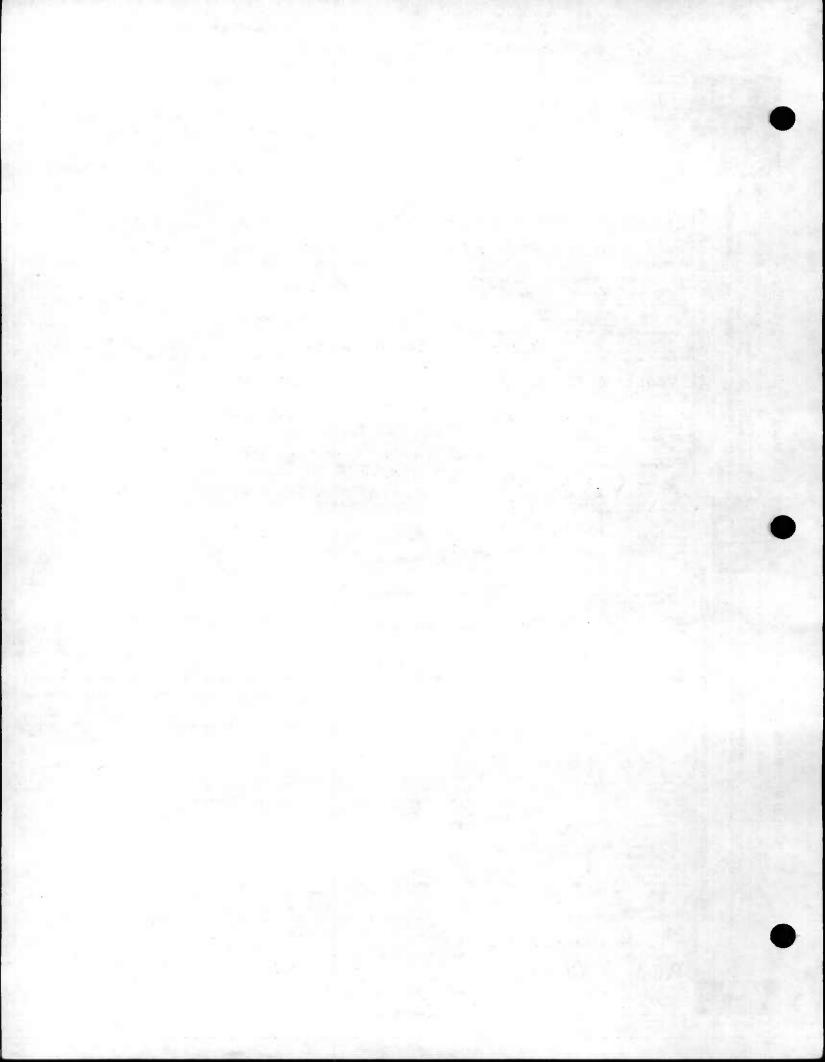
1 XBurial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 12/24/99 Elkridge, Md. Meadowridge Memorial Park 21. Signeture of Funeral Service Lic 22. Name and Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enforthe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause or each line. **Physician** tmmediata Cause (Final disease or condition resulting in death) Diabetes mellitis I /Medical Examiner y perfers in Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lest P.O. Box 68760, Due to (or es a consequence of): Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by the Congestive Heart failure 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, à 121 per kalemin A30 km. 9 24b. Wara autopsy findings eveileble prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1□ Yes 2DRo 1 Yes 2 Sto 25. Was casa referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitel: ↑ Phopatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 27. Manner of Death 28b. Time of 28a. Deta of tnjury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? After 1 Accident 5 Pending investigation a Funeral Director: After Selection of Funeral Director: After Selection of the fun selection of the selec 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide TG Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data end place, and dua to the cause(s) and manner steted. (Check only one) To the P within 2. 29d. Date signed (Month, Dey, Year) 29b. Signeture end-title of certifier 29c. License number ritem SR Dec 23,9 D28998 30. Name and addrass of person who completed causa of death (ttem 23a) (Type, Print) PRITAM 5 SAIN MD LAUREL 9101 cherry LA Shite 211 MD 20708 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State sparks Flegistrar DEC 2 8 1999

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

CHARLOTTI AMEND I	E TILLMAN TEMS: #23 PART I	State of Marylai	nd / Departme	nt of Health and	Mental Hy	giene Reg. No. 99 L	0549			
Physician	Decedent's Neme (First, Middle, La.	st)			2. Date of De Month	eath Day Year	3. Time of Death			
Physician /Medical	CHARLOTTE VI	RGINIA TILL	MAN		DEC.	22, 1999	0827 AM			
Examiner					or Location of Deat	h 4c. County of Deeth	1			
	JOHN HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State									
Funeral Director	5. Social Security Number 6. S 2/2-52-74 95 Usual Residence of Decedent	in. (Month, De	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) MARYLAND							
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death with the Marylar sma 23a or 28a-f show ir must be notified at marral Director	MD BALTIN	DORF	DUNDALK				1 ☐ Yes 2 ☐ No			
Universely with the Ma interdeath with the Ma interdeat 23 or 23e-1 s interdeat Director	10e. Street and Number			Tip Code		10g. Citizen of Whet Co.	untry?			
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ter death thema 23	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		edent of Hispanic Origin? secify Cuban, Mexican, Pu	(Specify Yes or No	Specify Yes or No- to Rican, etc.) 14. Race - American Indien, Black, White, etc.				
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- M 44 F	LERH MARSH 1 20a. Method of Disposition	TOTHER 20b.	Place of Disposition (A	VILSON AVE.	Date	20c. Location - City or	Town, State			
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Baltimore, semit. Pages 1 a Department of He moortant: If item any injury or othe	4 □ Donation 5 □ Other (Specify 21. Signature of Funerel Service Licen	" BI	ALTIMORE 22 Name	CEMETERY	13/27/9	BALTIMOR	E, MD			
Balti permit. Departm Importa any inju	21. Signature of Fullered Service Econ	300		and Address of Facility NBURG FUNC						
	Tobut 6. Ub	tenly hic Dood	02 6009	HARFORD	ROAD BA	LTIMORE MD	21214			
Physician // // // // // // // // // // // // //	23a. Parks. Enter the disease, or compandot, or heart failure. List only of immediate Cause (Final disease or condition	CIRRHO		HE LIVER	nac or respiratory e	irrest,	Approximete Intervel Between Onset end Death			
P. CHISTHIESE	resulting in death)	Due to (or as a consequence o	n):						
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8760, ste be executed hysteian and he burial-transit sical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or as a consequence o	n):						
Cords, P.O. Box 68760 v requires that the death certificate be been signed by the attending physicia should be datached for use as the bur letted by Physician/Medical	that initiated events Due to (or as a consequence of):									
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Vital Records, Jen: The law requires the artificate has been signe actor, page 2 should be Be Completed by				0.00	24a. Wes	ormed?	Vere autopsy findings weilable prior to completion of cause of death?			
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ital en:] tor, p	25. Was case referred to medical			26. Place of E	Death (Check only i					
hysicianis certification		Hospital: 1 ☐ Inpatient 🗓 🗓	ER/Outpatient 3 1	Other		dence 6 □Other (Spec	ei(v)			
		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No		how injury occurred				
Division c tal or attending P is after death. si Director: After t led in by the funera Certification:	3 Suicide 6 Could not be 4 Homlcide determined	28e. Place of Injury - At h building, etc. (Speci			Street and Number or Ru wn, State)	rel Route Number,				
To the Hospital of within 24 hours a To the Funeral D completaly filled I Medical Ce		reiclen: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and pla on, in my opinion, death oc	ice, and due to the courred et the time,	cause(s) and manner as date end place, and due	stated. to the cause(s)			
To the	29b. Signeture and title of certifier		2	9c. License number		29d. Date signed (Month	o, Dey, Year)			
	D. 1	M.L.		O.C.M.E	1 (-1	DEC. 23,	1999			
	30. Name and address of person who o	completed cause of death fitted	m 23a) (Type, Print)							
	Dennis J. Chu			reet, Baltim	ore, Mar	yland 21201				
State	31. Date filed (Month, Day Year)	32. legistrar's Sign		rocks						
Registrar	SEA IN 1 194	77								

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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Physician FEINOUR M. VERA 9.40pm DECEMBER 17 1999 /Medical 4a Facility Name (If not institution, give street and number) 600d Samarian Hos. 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 5601 LOCHRAVEN BOULEVARD BALTIMONE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplece (Steta or Foreign Country)
PENNSY VANIA **Funeral** 1□ M 2☑ F 213202253 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haeith and Mantel Hyglane. Important: If them 27 is marked other than "natural", or thems 23s or 28e-f show any injury or other treumstic event, the Maddal Essenies. 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2/ No MO BALTINONE Funeral Director BALTIMONE MU 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code GLEN LOE RPAIN 2510 21234 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 14. Raca - American Indien. Bleck, Whita, etc. 1 ☐ Yes 2 N No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Be Completed by 3.2(Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete-Zip Code) Himore 916 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date Dec 20 1 Burial 2 ☐ Cremetion 3 ☐Removal from Stete 4 Donation 5 Dother (Specify) Moreland 22. Neme end Address of Fecility vaus Funeral Chapel Baltimore Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Batween Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) WEEK /Medical SEPSIS

Due to (or as a consequence of): Examiner Physician/Medical Examiner DAY PERFORATION VIOLV The lew requires that the deeth certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, DU GESTUE KEART Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Š 24b. Wara autopsy findings eveileble prior to completion of cause of daeth? Be Completed 24e. Wes en eutopsy 1 Yes 2 No After this cartificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1□ Yes 20 No Certification: To To the Hospital or Attending Phy within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral is 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date end plece, end due to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et tha tima, date and place, end due to the ceusa(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) omer pro hale, MO P13455 DECENSION 17,1899

State Registrar

DHMH 16 Rev 6/95 DEC 2-8

DEC 2 8 1999

31. Date filed (Month, Day, Year)

DOMINIQUE MALL

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

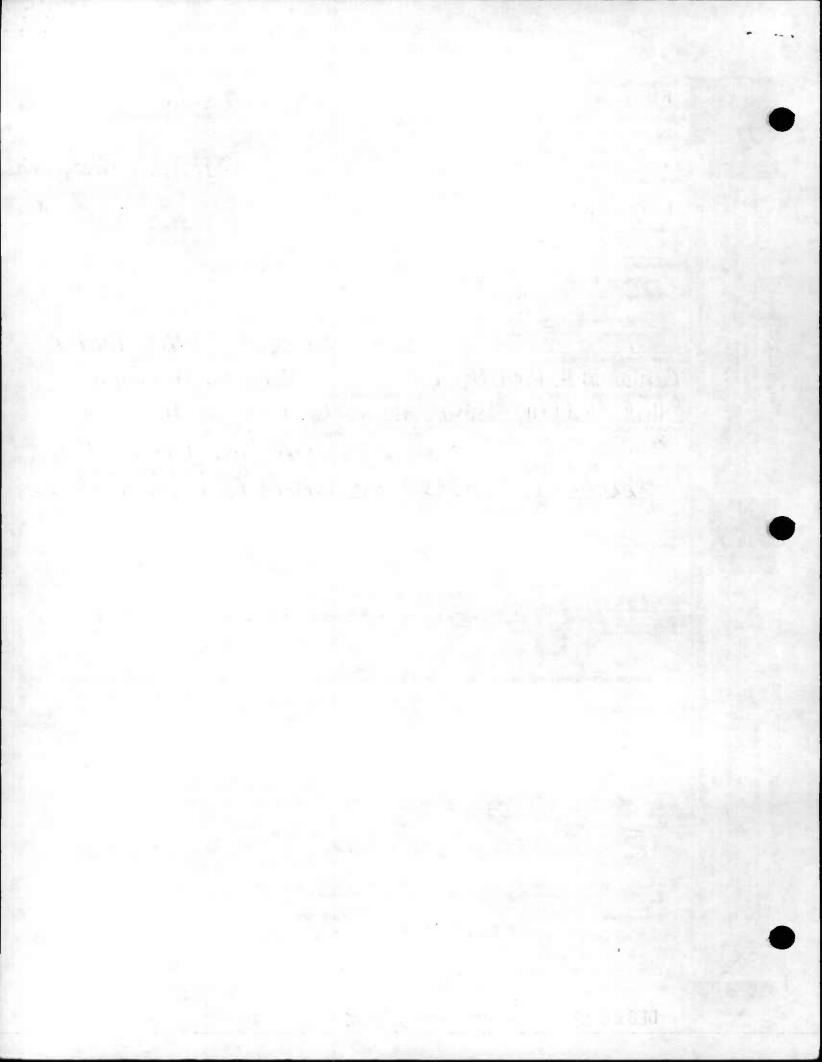
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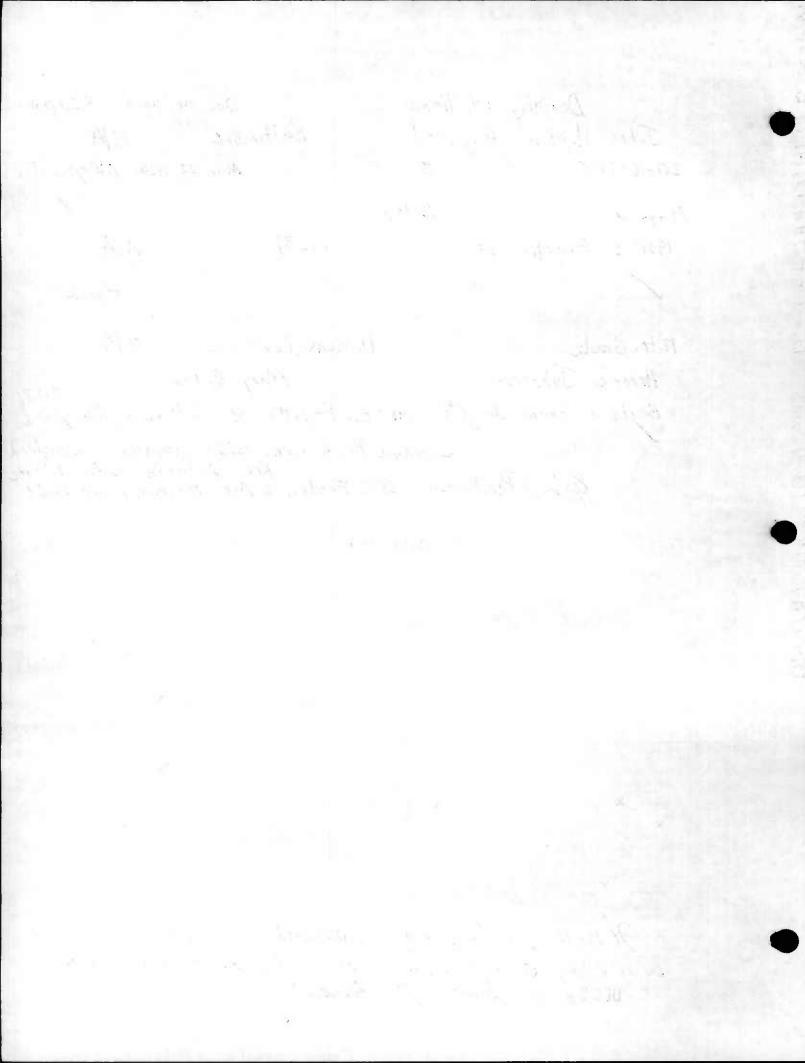
ORIGINAL

KAVEN BOULEVARD

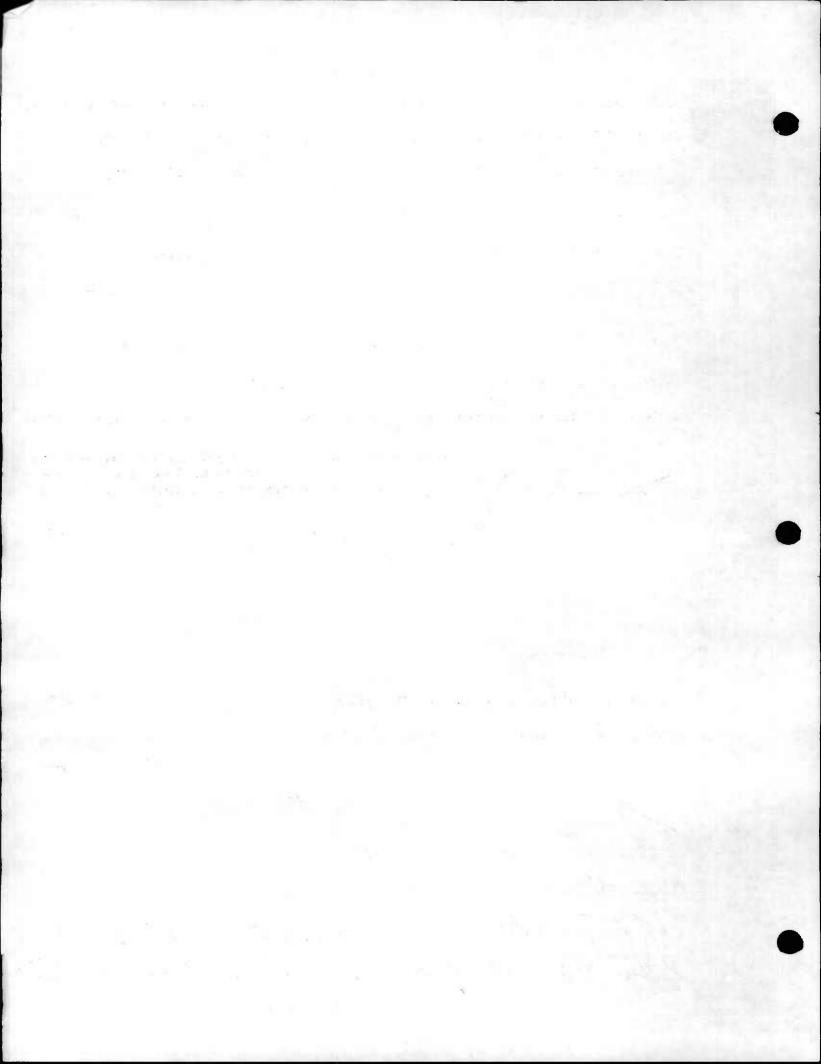
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Physic	ian	Lewis (AKA Louis		on Li	right			Month	Day	Year	3. Time of Death		
/Medi		4a. Facility Name (If not institution, giv	•		TIGHT		4b. City, Town, or	Decembe	r 26 1	999 of Death	2:55 p.m.		
Exami	ner	Genesis Elder Car			Cente	r	Randal1			imor			
Funeral Director		Social Security Number 6. S	Sex 7.	Age (In yrs. Ia		If Under 1 Ye Months Day	ar If Under 24 Hrs.		Year)	9. Birth	place (State or Foreign intry)		
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ith with the Marylar 23a or 28a-f show	Į.	10a. State 10b. County Maryland			Town or Loca timore	ition					10d. Inside City Limits 1 TYPES 2 No		
the 128a	Director	10e. Street and Number				10f. Zip Cod	0	1	0g. Citizen of V	What Cou	intry?		
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72 hours after death with the Maryland natural, or items 23s or 28s-1 show after Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	No.				o Rican, etc.)	Black, White, etc. Specify: Black				
Mal ylailla 4.12.13-0020 d 2 should be filed within 72 hours aft th and Mantal Hyglane. 7 is marked other than "natural", or traumatic event, the Medical Exam	ted	15. Decedent's Ed	ducation		16e. Decede	nt's Usual Oc	cupation	king	16b. Kind of Bu	usiness/Ir	ndustry		
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emit. Pages 1 ar Pepartment of Haa mportant: if Itam 3 iny injury or other INCE.			Removal from Sta	COL	metery, crema	tory or other	olace)		20c. Location -				
permit. Pages Department of Important: If it any injury or o				Mt	Zion	Cemeter	ry1	2/30/99	Landsdo	wne,	Maryland		
Departimon Importanti any in		21. Signature of Funeral Servica Licer	1500		22.	Name and Ad	dress of Facility De	rrick C.	Jones	Fune	ral Home		
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/Medical Examiner		disease or condition	. Du	Como	-an	, +	brosi	1			YRS		
LAdiliniei		resulting in death)	· · · · · · · · · · · · · · · · · · ·								1		
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cate be axecuted physician and the burial-transit	dic	that initiated events		Due to (or a	as a conseque	inca of):							
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The law te has b	dm									of	f death?		
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hysi this o	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		R/Outpetient	3LI DOA		ome 5 Reside		-	fy)		
Ing F	6	27 Manner Death Natural 5 Pending	28a. Dete of In (Month, I	Day Year)	28b. Time of Injury		njury at Vork?	28d. Describe ho	ow injury occur	red			
or Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	cat	Accident investigation 3 Sulcide 6 Could not be					Yes 2 No						
or At	틭	4 ☐ Homicide determined	28e. Place of	Injury - At hometic. (Specify)	ne, farm, stree	l, fa <i>c</i> lory, offic	ca	City or Town		er or Hur	ral Route Number,		
orai C	ပို	20-0-20-											
Hos 24 ho Fune staly 1	edical Certification:	29a. Certifier Certifying Ph (Check only one) Medicai Exan	niner: On the basis	of examination	edge, deeth o on and/or inve	ccurred at the stigation, in m	time, date and place y opinion, death occu	, and due to the or rred at the time, d	euse(s) end me ate and place, :	enner es s and due t	steted. to the cause(s)		
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral di	Mec	29b. Signature and title of certifier	and manner	วเลเยนี.		29c Line	ense number	2	9d. Date signe	d (Month	Day Year)		
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1 -		177000	000			D	2035)	17/2	-/,	///		
$\langle \bigcirc \rangle$		30. Name and address of person who	completed cause o	of death (Item 2	23a) (Type, P	int)	THE A	011		1.			
		A DOIN HOOM (Marth ST.	10.	500	MEZ	MIL	GE RI	MIKE	_) //	LIC	- 191		
Sta		31. Date filed (Month, Day, Year)	9 1000k	strer's Signetu	ITH ITH	9	land,						
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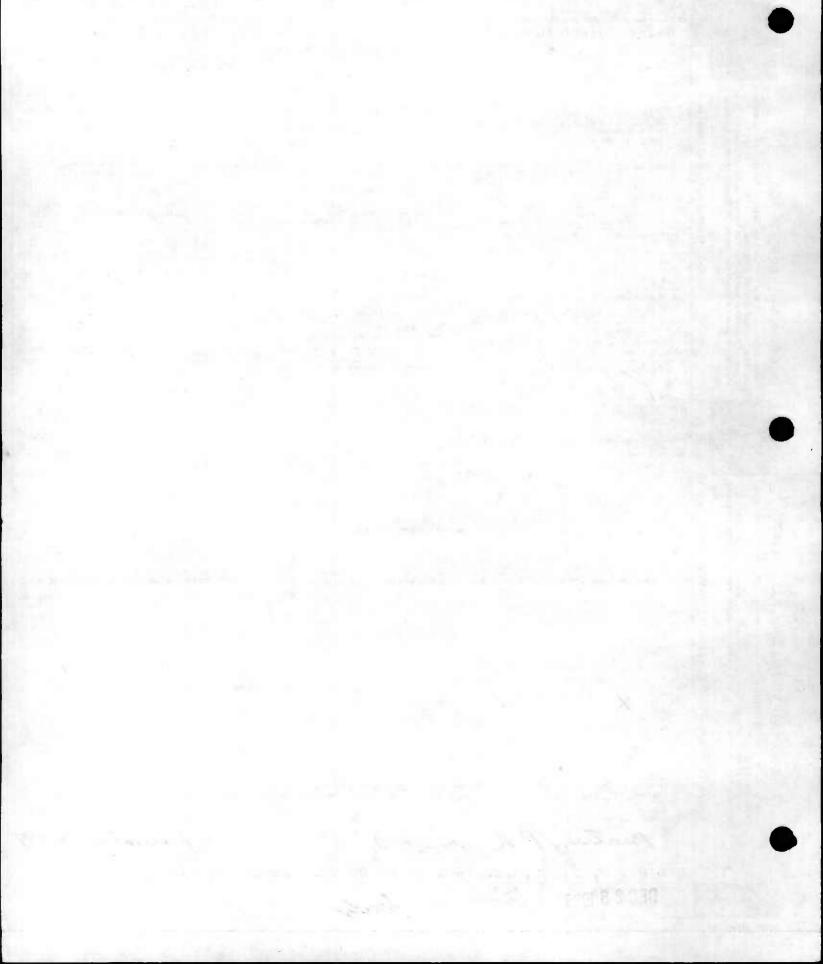


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State of Maryland / Department of Health and Mental Hygiene 9 9

					e of Death		Reg. No.	40553	
Physician	1. Decedent's Name (First, Middle, Last,					2. Date of De Month	Day Ye		
/Medical	MINA					DECEMBE	-		
Examiner	the City Town or Location of Dooth								
	5. Social Security Number 6. Sec			If Under					
Funeral Director	056-18-4753	x 7. Age (In yrs		Months		8. Date of Bir (Month, Da DEC • 2	7, 1913	Birthplace (State or Foreign Country) GERMANY	
P M	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation		-		10d. Inside City Limits	
vith the Marylar to 284-f show be nutfled at Director	MD N/A		BALTIM		1 🗓 Yes				
afer death with the Maryla after death with the Maryla or thema 23a or 28a-f elvo more man be notified at Puneral Director	10e. Street and Number 2703 TANEY ROAD	0	10g. Citizen of What Country? U.S.A.						
D 1 1 2 C	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Yaar or Dates:	J,S. 13	. Was Deced If Yas, spec	dent of Hispanic Origin? cify Cuban, Mexican, Pue 21 No Specify:	(Specify Yes or No orto Rican, etc.)	Yes or No- n, etc.) 14. Race - American India Black, Whita, atc. Specify: WHIT		
ed within 72 hours ygiene. or then "netural", rt, ne wedler E.	15. Decedent's Edu (Specify only highest grade	cation e completed)	orkina	16b. Kind of Businass/Industry					
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e filed v all Hygle other to vent, p) +	HOME	MAKER	40.44.4.4.4		OWN HOME		
Z should be filed and Mental Hyg and Mental Hyg le marked othe sumatic event,	17. Father's Nama (First, Middle, Last) HERMAN	K	AUFMAN	IN	KLARA	ame (<i>i-irst, Middle</i> ,	Maiden Sumame) OPF	ENHEIMER	
should had Men umarke	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mai	ling Address	(Street and Number or	Rural Route Numb	er, City or Town, Sta	te, Zip Code)	
CENL	SUSAN OBERFELD /	DAUGHTER	60	015 WO	ODCREST AVE	NUE - BAI	LTIMORE, N	4D 21209	
2 8 5 = 5	20a. Method of Disposition		Place of Disp	osition (Nan	ne of ther place)	Date	20c. Location - City	or Town, Stata	
Pages ment of I	1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		EVRA A	AHAVAS	CHESED	12/24/1	999 RANDA	LLSTOWN, MD	
Deficiency of permit. Pages 1 er Department of Has important: If Nem any injury or other pages.	21. Signature of Funeral Service License		-	Z Name an	d Address of Facility		ISON & BRO		
	PA 100	47			EISTERSTOWN			E, MD 21208	
	23a. Part1. Enter the disaasa, or compli shock, or heart failura. List only or	cations that caused the dea ne cause on each line.	th. Do not e	nter tha mod	e of dying, such as cardi	ac or respiratory a	rrest,	Approximate Intarval Between	
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at the death ce d by the attendi letached for uss	Part II. Other significant conditions con	tributing to death but not res	sulting in tha	underlying c	ause given in Part I.	23b. Did	tobacco use contrit	oute to the cause of death?	
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Physician: The lew requires that the death certificate be executed this certificate has been signed by the attending physician end real director, page 2 should be detached for usa as the burial-transit: To Be Completed by Physician/Medical Examis:							an autopsy 24	4b. Wara autopsy findings available prior to completion of cause	
has by ye 2 s								of death?	
Com						10	res 200 No	1 □ Yes 3 No	
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Physician: this certificinal director.	TIL Tes Zenno		28b. Tima			7	dence 6 Other (Specify)	
ding P. After funer	27. Manner of Death 1 Natural 5 ☐ Panding	28a. Date of Injury (Month, Day Year)	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	now injury occurred				
Attending or death. ector: After by the fune Ification	2 Accident Invastigation 3 Suicide 6 Could not be								
tal or Attending P is efter death. al Director: After t led in by the funers Certification:	4 Homicide determined	28e. Place of Injury - At h building, atc. (Special		treet, factory	actory, office 28f. Location (Street and Number or Rural Routa Number City or Town, State)				
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one) 29a. Certifying Physics 2 Medicat Examination	sician: To the best of my knoter: On the basis of examine and manner stated.	owledga, dea atlon and/or in	th occurred a	at the time, date and pla- in my opinion, daath oc	ce, and dua to tha	cause(s) and manna data and place, and	r as stated. dua to tha cause(s)	
Mec Mec	29b. Signature and title of certifier	and mariner stated.		290	. License number		29d. Date signed (M	Ionth Day Year)	
or or or)	no.			16492			/ 100	
	, Juany	r. Nuger	~ M	.0	to the second		Necm	on 22/999	
()	30. Nama and address of person who co BEATRIZ F, DIZO	mpleted causa of death (Item N, M. D., 760)			IVE, TOWS	ON, MARY	LAND 21	1204	
State	31. Date (1) E (2 8 1999	32. Registrar's Signa	ature	1				The	

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4a Facil	, 11-		7)			4b City	1	ocation of Death	4c. County			
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216	-18-4209	1□ M 2⊠ F		87 Yrs.		Days Hou		SEPT.10	7,1912	Count	v)	MD
10a. Sta	te 10b. County	/7	10c. Cit	y, Town or Loc		ALTIMO	DE			10	d. Inside C	ity Limit
		A			10f. Zip (KE		10g. Citizen of \	What Count	y?	
71	21 PARK HEIGH	HTS AVENUE	#706	5	. 35	2121	.5		U.S.A	A.		
11. Mari	tal Status	12. Was Deceder Armed Forces	nt Ever in U	,S. 13. W	as Decede Yes, specif	nt of Hispanic	Origin? (S	pecify Yes or No- o Rican, etc.)	14. Rac	e - America ck, White, e		
4a Facility Name (If not institution, g 5. Social Security Number 216-18-4209 Usual Residence of Decedent 10a. State 10b. County MD N/ 10e. Street and Number 7121 PARK HEIGH 11. Marital Status 1 Never Married 2 Married 3X) Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La: HENRY 19a. Informant's Name/Relationship Re 13 RITA ZUCKERMAN 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation, 5 Other (Specify only highest g 21. Signature of uneral Service Lice 23a. Part 1. Enter the disease, or condition, sidenses or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	If Yes, Give			1 ☐ Yes 2 ☒ No Specify:				/: V	WHITE			
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				Place of Dispos			1	Date	20c. Location	City or Tov	m, State	
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21. Sign	nature of uneral Service Li	censee / //	1	22.	Name and	Address of Fa	acility S	OL LEVIN	ISON & E	BROS.,	INC.	
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23a. Pa	rt1. Enter the disease, or cock, or heart failure. List or	omplications that caus nly one cause on each	ed the deat line.	h. Do not ente	r the mode	of dying, such	as cardiad	or respiratory ar	rest,		Approxima Interval Be Onset and	tween
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25. Was	case referred to medical					26. F	Place of De	1 🗆 v		of c] No
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25. Was exar 1 [] 27. Man	case referred to medical niner? Yes 2000No	Hospital: 1 Xinpa 28a. Date of Ir (Month, I	jury	ER/Outpetient 28b. Time of Injury		Other		ath (Check only o	nne)	of o	Yes 2	□ No

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Phys within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral di

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to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. RES - 0

29d. Date signed (Month, Day, Year)

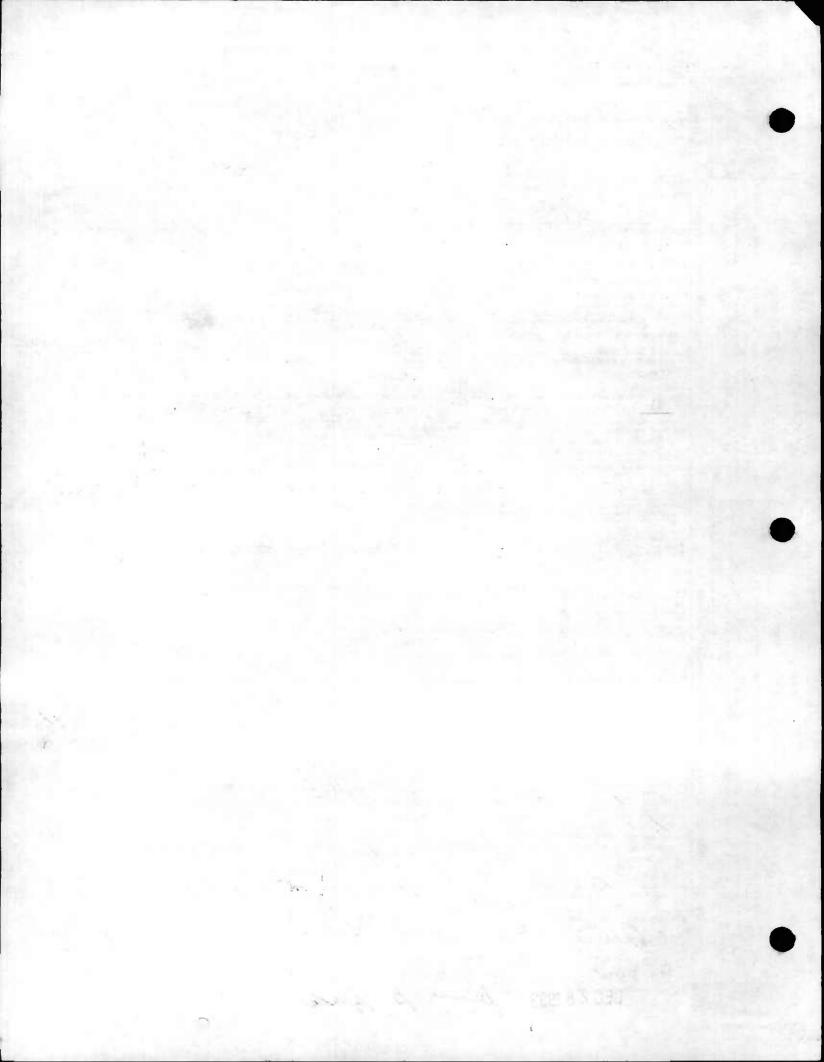
30. Name and address of person who completed cause of death (them 23a) (Type, Print)

Arthur Li, Sinai Hosfita

31. Date filed (Moeth Day, Year) 1999 32. Registrar's Signature

oaks

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40555 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** December 25 Margaret Ridgely Williams 1999 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baldimore
If Under 24 Hrs. General Hospital 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (Irl yrs. last birthday) Birthplece (Stete or Foreign Country) 6. Sex **Funeral** Min. Months Days Hours 1□ M 2√F 79 Director Mar. 28, 1920 Maryland 213-12-6484 Usuel Residenca of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits Hygiene. other than "natural", or items 23s or 28s-f ahow ord, its Medical Examiner must be notified at YOYes 2□No Directo Baltimore MD 10f. Zip Code 10g. Cilizen of Whel Country? 10e. Street end Number 501 W. Franklin 21202 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Reca - Amarican Indian, 11. Maritel Stetus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours aftar Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or item any Injury or other traumatic event, the manical seconds. 1 ☐ Yes 2X No II Yes, Give Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Bernard Hodges Williams Sr. Martha Dorsey Lansdale 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Williams - Sister-in-Law 1306 Cedar Park Road, Annapolis, MD 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1

Buriel 2 □ Crametion 3 □ Removel Irom State All Hallows Episcopal 12/30 Davidsonville, MD 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Sarvice Licenses 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridegly Avenue, Annapolis, MD 21401 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Final Ineumonia disaese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner attanding physician and for use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Physiclan/Medical Due to (or es e consequenca of): bed Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuee of death? been signed by the should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy lindings available prior to completion of causa of deeth? Completed 24a. Wes en autopsy s certificata has b director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 PNo director. Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To After this funeral 28a. Dete of Injury (Month, Day Year) 27. Mangar of Deeth 28b. Time of 28c. Injury el Work? 28d. Dascribe how Injury occurred 1 Naturel 5 Pending 1 TYes 2 No s after oc. investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Locallon (Straet and Numbar or Rural Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, straal, factory, offica building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Dirac completaly filled in by 4 | Homicide 29a. Certifier Medical 🕊 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signetura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) Kavita Kalra, M.D. o Maryla Kalra

DHMH 16 Rev 6/95

Registrar

illed (Month, Day, Year)

32. Registrar's Signatura

death with the Maryland

altimore, Maryland 21215-0020

The law requires that the death certificate be executed

Box 68760

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Division of Vital Records,

or Attending Physician:

WILLIAMS

MARGARET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40556 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12/21/9 9ay 1050AM Kosebud WALKET 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth BALTO RITChie HOSPICE 5. Social Security Number 8. Date of Birth (Month, Dey, Year) If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex Min. Months Days Hours 1□M 2DF 48 9421 67 5. C. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md BALTO. 1 Yes 2 □ No N. 10f Zin Code 10g, Citizen of What Country? 10e Street and Number 4.5. 2511 LAURETTA AVE 12 23 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. BO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOL DUC erk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHAPEL WALKer PAR 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Balto . md 21239 1247 WEAVER Windon 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State BALT. Conty Buriel 2 ☐ Cremation 3 ☐ Removal from State 2/27/99 Cem 4 ☐ Donation 5 ☐ Other (Specify) WoodLAURN 21. Signature of Funeral Service Licensee Locks J 304 n. NOCKS Enter the disease, or complications that caused the death. Do not after the mode of dying, or heart failure. List only one ceuse on each line. Approximete Interval Betwee Onset and Dee Immediate Cause (Final disease or condition resulting In death) Henatoullular Carcinona Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Type 2 Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Sother (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and menner es steted.

/Medical Examiner

To the Hospital within 24 hours a To the Funeral C

Physician

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Examiner

Director

Funeral

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Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at

pemit. Pages 1 and 2 should be filed within 7 Departmant of Haaith and Mantal hygiene. Important: If Item 27 is marked other than "n any Injury or other traumetic event, "to Mad any Injury or other traumetic event, "to Mad

Physician

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Registrar

31. Date filed (Month, Dey, Yeer)

29b. Signature end title of certifier

(Check only one)

M.D.

29c. License number D51789

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

12/21

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

MG Mclaof, M.D., 6565 N. Charles St HZO3, TOWSON, MD 21204

32. Registrar's Signature

DEC 2 8 1999

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Souls

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND^{ASP}TEMS: #23 PART I, 27 I

State of Maryland / Department of Health and Mental Hygiene PER MEO G780 Certificate of Death Reg. No.	00	1055
PER MEO G780 Certificate of Death Reg. No.	33	40557

Physician
/Medical
Examiner

Funeral

Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana. Important: If item 271s marked other than "natural", or harms 23s or 28s-f show any injury or other traumatic avant, the Madical Essent serms the notified at anothes.

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death carificate be assocuted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit

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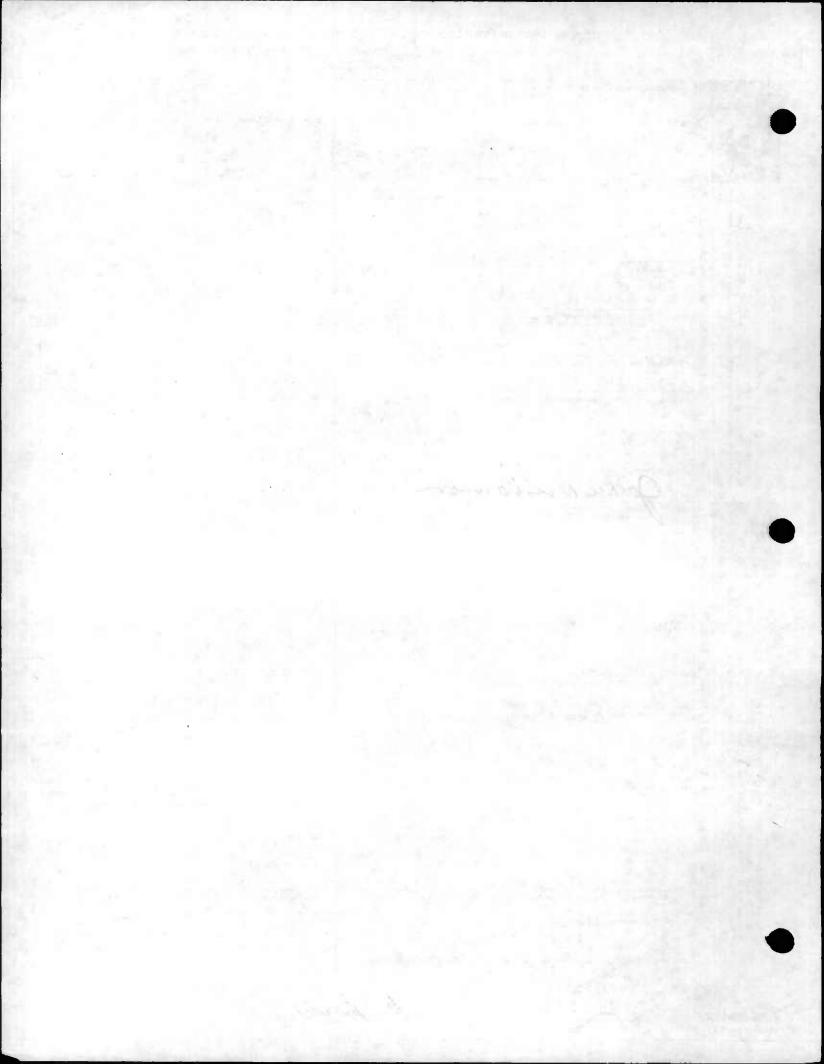
State Registrar

DHMH 16 Rev 6/95

DEC 2.8

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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Reg. No.	9 1	+0558
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6	30. Name end eddress of person who co	mpleted cause of death	(Item 23a) (T	ype, Print)	771	4.00	Jue B		10 11	47 21
	WILLIAM INI A	THY 41/1/2	THE .	-1 /1	11/ 14/	AITA	1111	V-1	1 1 //	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Tounce Eurcle December 07:59 25, 1999 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Hookins Johns Baltimore Hospital | Months | Days | Hours | Min. | Sept. 23,1906 | North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1□ M 2√ F 93 Yrs. 219-10-4601 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 329 S. ELLWOOD AVENUE 21224 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes ALXNo If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: 3 XWidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 NURSE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN P. GRACE LYDIA ARABELL DEBOARD 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID T. YOUNCE/ SON 329 S. ELLWOOD AVENUE BALTIMORE, MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) OAK LAWN CEMETERY BALTIMORE, MARYLAND 12/29/99 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility LILLY & ZEILER INC. FUNERAL HOME CONKLING STREET, BALTIMORE, MARYLAND 21224 700 S. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) 48 hours Due to (or es e consequence of) Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 1 No 26. Place of Deeth (Check only one) Hospitel: 1) Linpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be illed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or han any injury or other traumatic event, the Medical Franch

Saltimore, Maryland 21215-0020

attending physician and for use as the burial-trans this certificate has To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vitai Records,

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. atrial fibrillation 2 Be Completed 25. Wes case referred to medical 1 Ves 2 No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 SNetural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29c. License number LES-000

29d. Dete signed (Month, Dey, Year) December 26, 1999.

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Julie Huang, M.D. Torrev 110,

Johns Hokins Hospital. baltimore, Maryland 21287 31. Dete filed (Month, Day, Year)

State

DEC 2 8 1999

32. Registrar's Signature

works

Registrar **DHMH 16 Rev 6/95**

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death 8.00 AM December 26 1999 June Ann Young 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIE GLEN ANNE ARUNDEL NORTH ARUNDEL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 13,1949 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 195-42-7821 1 M 2 F 50 Yrs. Pennsylvania Usual Rasidence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1805 Ouebec Street 21144 IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Samuel Shenk Catherine Espenshade 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) George R. Young Sr. - Husband 1805 Quebec Street, Severn, MD 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 12/29 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Ligans 22, Nama and Addrass of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate tnterval Betwean Onset and Death Immediata Cause (Final disease or condition resulting in death) - SEPTIC SHUCK Due to (or as a consequence of): BOWEL OBSTRUCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last of the RECTUM (welly invenive advanced & CARCINOMA currete chable Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown RESPIRATORY FAILURE 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident

The lew requires that the deeth certificate be executed Box 68760, the of Vital Records, P.O. or Attanding Physician: this After this funeral of Division after death.

Director: Aft
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Physician/Medical

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ould be filed within 72 hours after Mental Hygiens. erked other than "natural", or its

Pages 1 and 2 should

Department of I

Physician /Medical

Examiner

Maryland 21215-0020

Completed by Be

edical Certification: To filled in by

To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

State Registrar

DHMH 16 Rev 6/95

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29b. Signature and title of certifier

3 Suicide

29a. Certifier 000)

4 ☐ Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARIF WURTH

MI

ARUNDER 32. Registrar's Signature

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

0 51245

ORIGINAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as stated.

Leading Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29d. Date signed (Month, Day, Year) December 26, 1999

HUSPITAL - MD

31. Data filed (Month, Day, Year)

6 Could not be determined

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** John Henry Yelton De Cambor 25 /Medical 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not institution, giva street and numbar) 4c. County of Daeth Examiner Hosp Carroll County Westminster 7 VV Tyrus | 1 Yaar | 1 f Undar 24 Hrs. | 8. Data of Birth | 9. Birthphace (Month, Day Year) | 1 Yaar | Hours | Min. | Sept. | 20, 1910 | North Carolina 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months 233-07-6152 89 Director Usual Rasidence of Decedant 10a, State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow than "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at Md. Carroll Director Westminster 1 Yas 2 No 10e. Street and Number 10f. Zin Coda 10g. Citizan of What Country? 410 Baldwin Park Dr. 21157 U.S.A. Funeral 12. Was Decadant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ğ Specify: White 3 Widowad 4 Divorced Completed 16a. Dacedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Educetion (Spacify only highast grada complated) 16b. Kind of Business/Industry and Mental Hydian Hygiene. Elementary/Secondary (0-12) Collaga (1-4or 5+) Black & Decker 12 Grinder 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be marked es 1 and 2 should b of Health and Ment f Item 27 is merked Jason Yelton Stellar Hill 2 19a. Informent's Nama/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 410 Baldwin Park Dr. T4 Westminster, Md. 21157 Elizabeth Yelton - Wife permit. Pages 1 at Department of Hea Important: If Itam; any injury or other 20a. Method of Disposition 20b. Place of Disposition (Nema of camatary, cramatory or other place) Data 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) New Lutheran Cem. Dec. 29, 1999 Manchester, Md. 22. Name end Addrass of Facility
Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md. 21102 23a. Part. En fr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or least failure. List only one cause on each line. Approximate Interval Batwean Onsat and Daath **Physician** /Medical Immediate Causa (Final Six months disease or condition rasulting in death) Examiner Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) rasulting in daath) Lest Part IJ. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. sete has been signed by the page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? An 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? certificete 1 🗆 Yas 1 Yas 2 No or Attending Physician: efter death. Be 25. Was casa referred to madical examinar? 26. Placa of Deeth (Chack only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Spacify) 1 Yas 25 No Certification: To Nunpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describa how injury occurred After 1 Natural 5 Pending efter death. Director: Aft 2 Accident 1 ☐ Yas 2 ☐ No investigation 6 Could not ba 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) in by 4 - Homlcide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Tertifying Physician: To tha best of my knowladga, death occurred et tha tima, data and place, and dua to tha cause(s) end mennar es stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred et the time, deta and place, end due to the ceuse(s) end manner stated. 29a. Cartifier Medical 29b. Signature and title of 29d. Date signed (Month, Dey, Yeer) 30. Name and eddress of parson who complated ceusa of death (Itam 23a) (Type, Print) memorial Ave, Westminster,

State Registrar

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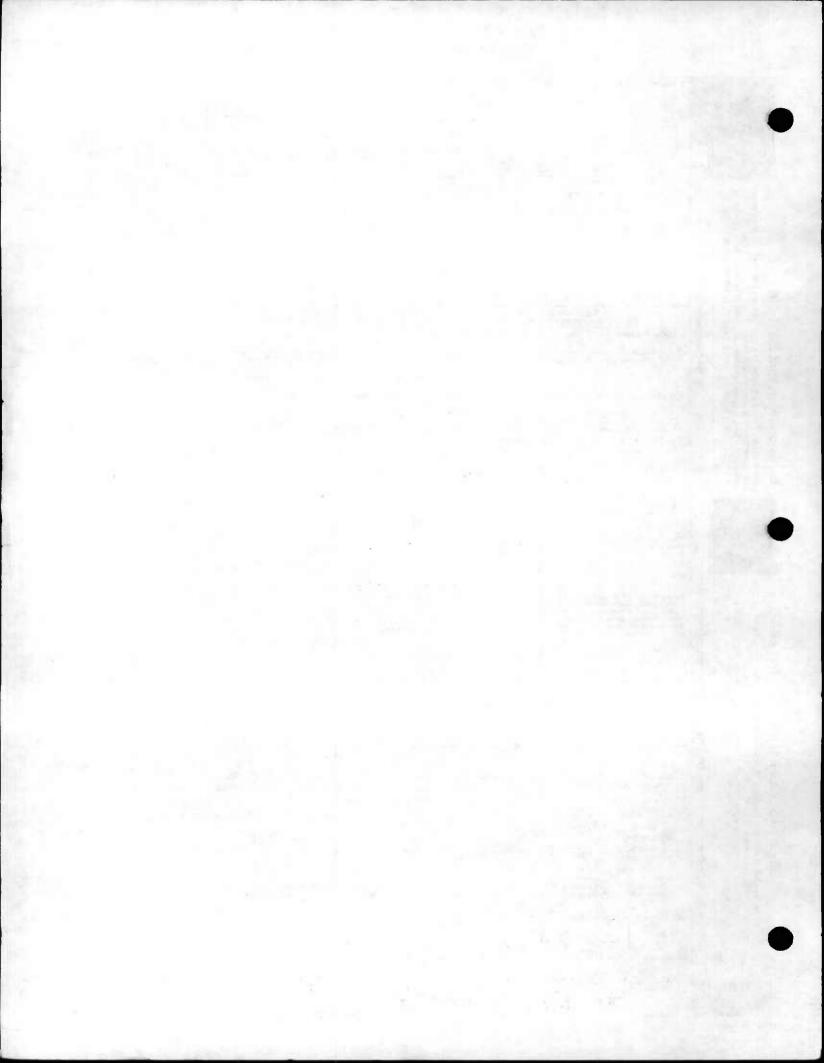
State of Maryland / Department of Health and Mental Hygiene Q Q 40562 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Deeth Month **Physician** Francis Erwin ANTHONY Dec. 1999 6, 21:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Min Hours 1 N M 2 □ E Yrs 367-18-9846 Dec. 5, 1918 Director 81 Michigan Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yas 2 ☑ No Director MD Garrett Mt. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be n 607 P Street Apt. 24 21550 IISA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☑Yas 2 ☐ No WW II If Yes, Giva Year or Dates: Korean 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yas 2 No Specify: White Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hyglene. Other than 'n Elementary/Secondary (0-12) College (1-4or 5+) +1Caretaker Motel 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flie Department of Health and Mental My Important: If Illem 27 is marked other any Injury or other traumatic event 18. Mothar's Neme (First, Middle, Maiden Sumame) Be Mervin _____ Anthony Delta _____ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenia McKinney/granddaughter 111 F Street, Mt. Lake Park, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery 12/9/99 Oakland, Maryland 21. Signature of Funeral Service, Licenti 22. Nama and Addrass of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on aech line. Approximata Interval Between Onset end Death **Physician** tmmediate Cause (Final diseasa or condition resulting in death) /Medical acute myocardial infarction 2 wk Examiner Dua to (or as a consequence of): physician and s the burial-transit b. congestive heart failure
Dua to (or as a consequence ol): requires that the death certificate be executed wks Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) USO BS I for use as ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Y⊠ Yea 2□ No 3 Probably 4 Unknown chronic obstructive pulmonary disease Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No certificate Division of Vital al or Attending Physician: The setter death.

I Director: After this certificated in by the funeral director, pagin by the funeral director director, pagin by the funeral director dire 25. Was casa referred to medicat 8 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 EP/Outpatient 3 DOA 1 Yas 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? 1X Netural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatura and tale of certifie 29c. License number 29d. Data signed (Month, Day, Year) OW D30035 12-07-99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M . D . Donald R. Richter, 31. Date filed (Month, Day, Year) 1533 Memorial Drive Oakland, MD 21550 State - 8 DEC

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day 8100 Am Jennings Bradford Aaron, Jr. 12-11-99 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth at home, 6722 Whiton Road Snow Hill Worcester 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5-28-27 Birthplece (State or Foreign Country) Deys Min. XI M 2 F Months Hours 218-22-1004 Yrs. Balto., Md. Usual Residence of Decedent 10a, Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Md. Worcester Snow Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6722 Whiton Road 21863 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forces?
1½ Yes 2 □ No 1950—
If Yes, Give
Yeer or Dates: 1954 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 1954 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Nat'l Security Agen. Elementary/Secondary (0-12) College (1-4or 5+) Wallops Island, Va. 12 5+ electrical engineer 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Jennings Bradford Aaron, Sr. Hattie L. Travers (Aaron) 19a. Informent's Neme/Relationship (Type, Print) wife 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Patricia Phillips Aaron 6722 Whiton Rd., Snow Hill, Md. 21863 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State **X** Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Md. Veterans Cem. 12/15 | Hurlock, Md. 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility P.O. Box 87 icia L. Llennes Dennis Funeral Home, Snow HIll, Md. 21963 Approximete Intervel Between Onset end Deeth 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Immediete Ceuse (Final diseese or condition resulting in death) 10. WKS DER CARONIL ETPL SON Due to (or es e consequence of): MYOCARDIAL INSUFFICIENTY Due to (or es e consequence of): BENAL FAILURE Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 Unknown ALZHEIMURY DEMENTIA 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? PECUBITUS DA LEL 1 ☐ Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

attending physician and for use as the burial-transit

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certificate

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in by the

il or Attending P after death. Director: After t

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

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7 is marked other than "natural", or items 23s or 28s-f shor traumatic evant, the Mudical Examines: wast be notified at

al Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Nem 27 is marked other any injury or other traum-st.

the Maryland

death

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury Physician/Medical thet initieted events resulting in deeth) Last

> 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 Nursing Home STResidence 6 Other (Specify)

28c. Injury et Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signeture end title of certifier

25. Was case referred to medical

1 Yes 2 No

27. Menner of Deeth

1 Naturel 2 Accident

3 Suicide

29a, Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

D-05845

DEZ

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

28e. Dete of Injury (Month, Dey Year)

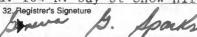
Robert C. La Mar, M.d. 104 N. bay st Snow Hill, Maryland 21863 x81. Dete filed (Month, Dey, Year)

State Registrar

1 4 1999 DEC

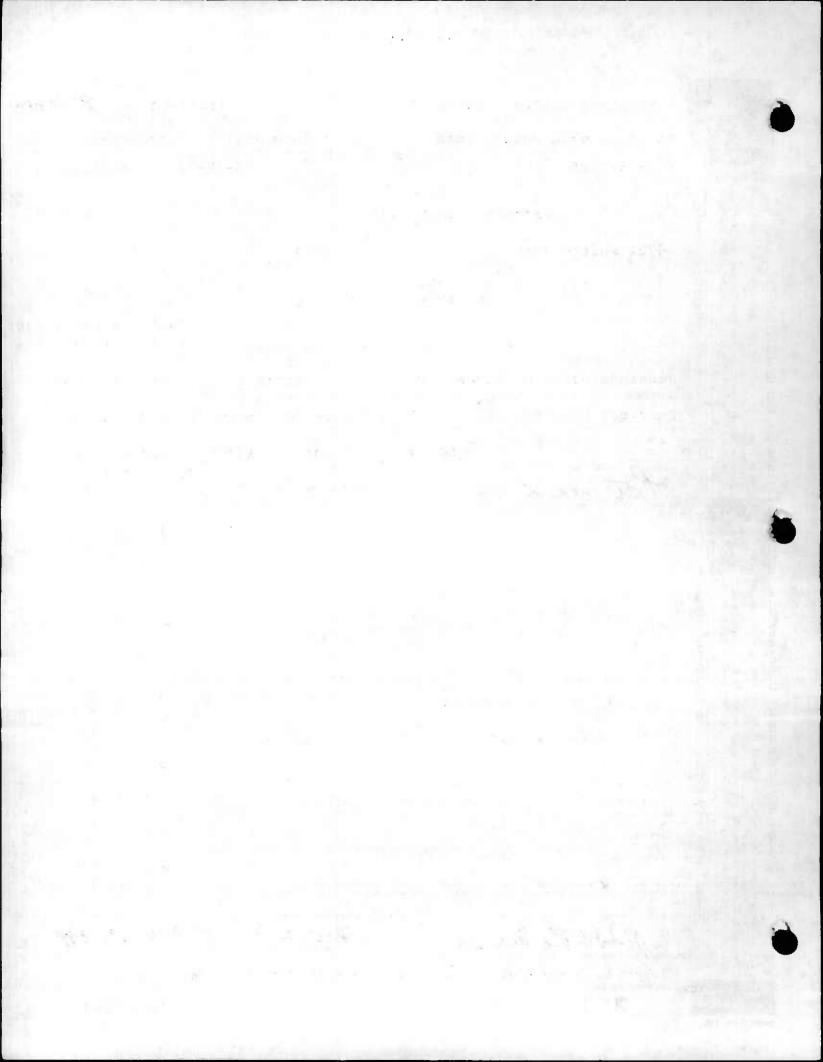
5 Pending Investigation

6 Could not be determined



28b. Time of

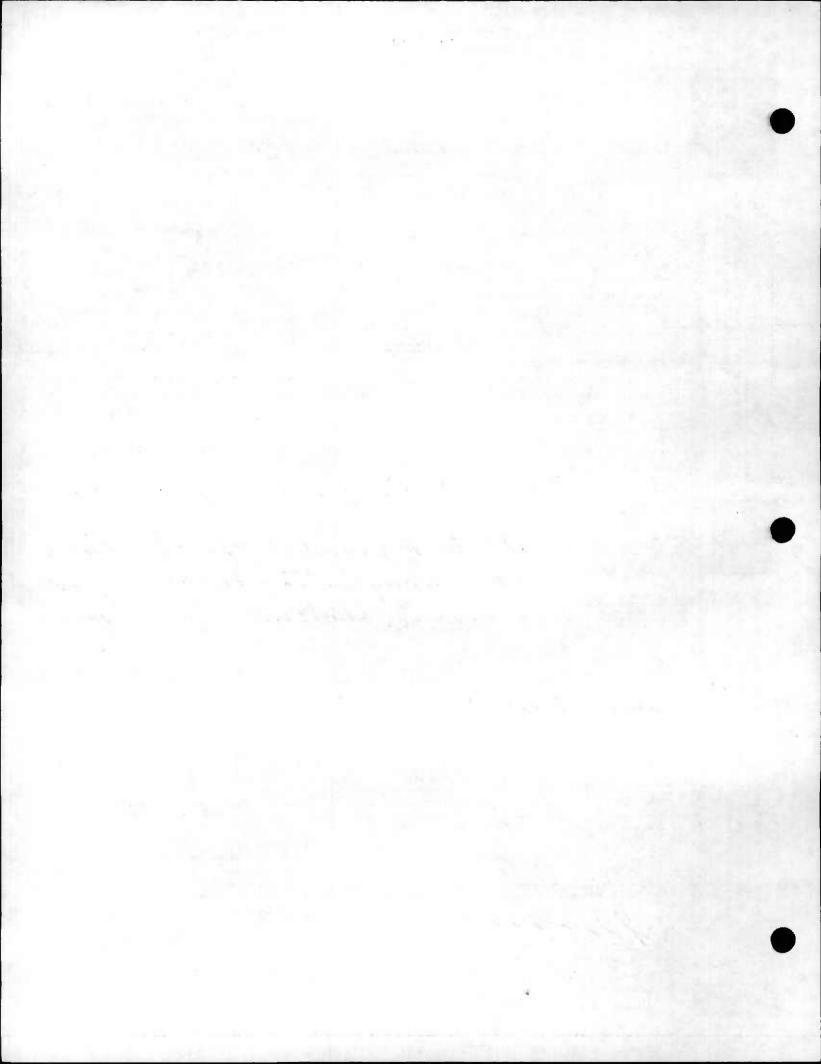
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	_	cedent'a Nam	e (First, Middle	, Lest)	FFF						2. Date of De			3. Time of Death
Physicia /Medica		Mary	Louise	Adams							DECEM!	BER 11,	999	10:10AM
Examine	de E	acility Name (I	f not institution,	give street	end number)				4b. City, To	own, or Lo	ocation of Dear	th 4c. Coun	ty of Deeth	
			Nursing						Ber				rcest	
Funeral		clal Security N		6. Sex 1 ☐ M 2	7. Ag	e (In yrs. last	Mon	ths Days	If Under Hours	Min.	8. Date of Bi (Month, D		9. Birthp	place (State or Foreigntry)
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ith the Maryler or 28a-f show	10e. S	Street and Nun	nber			-	7	. Zip Code				10g. Citizen of	What Cour	ntry?
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items items	11. M	larital Status		12. Wa	as Decedent med Forcas?	Ever in U,S.	13. Was D			igin? (Spe	ecify Yes or Ne Rican, etc.)		ca - Americ	
or it	_		ed 2 Marrie	ed 1 []Yes 2∐N¥ Yes, Give			s 210 No					^{'n} ∵ whi	
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in 72	Completed		15. Decedent's ify only highest	grede comp	pleted)	16	Sa. Decedent's (Give kind o life. DO NO	f work done Tuse retired	during mos	st of worki	ing	16b. Kind of	susiness/in	dustry
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d 2 should be filed within 72 hours at th and Mentel Hygiens. 7 is marked other than "natural", or traumatic event, the Medical Event	17. Fa	ather's Name (First, Middle, L	ast)		1 1/1	anager		18. Moth	er's Name	(First, Middle	, Maiden Sume		
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2 should be filed and Mentel Hygi Is marked other summitic event,		_	me/Relationsh		int)	1	9b. Mailing Add	ress (Street				per, City or Town	n, State, Zip	Code)
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of Herr		Method of Disp		2 D	alda Chaha	20b. Place ceme	of Disposition tery, cremetory	(Name of or other plea	ce)		Date	20c. Location	- City or To	own, State
Pages nent of l ant: If its ury or o			☐Cremation 5 ☐ Other (Sp.		el from State		Baptis			12	2/14/99	Pocomo	ke Ci	ty, MD
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Physician /Medical Examiner	Imme	Pert1. Enter the ahock, or hear added Cause (I use or condition ting in deeth)	t failure. List o	only one ceu	se on each lir	ne.	o not enter the	mode of dyir	ng, such es	cardiac o		arrest,		Approximete Interval Between Onset and Death
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ne Hospital or Attending Physician: The lew requires thet the death certificate be associed in 24 hours after death. The Funarial Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending the funeral Certification. The Population and pletely filled in by the funeral filled in the funer	Immedisearesult Sequences	ahock, or hear ediate Cause (I lise or condition ting in deeth) entially list cor , leeding to im e. Enter Unde e (Disease or initiated events ling in death) L As case referr caminer? Yes 2 1 Accident Suicide Homicide Certifier (Check only	ed to medical Poly Solutions, mediate riving injury ast Cant condition Poly Solution investige 6 Could not determing investige 6 Could not determing 2 Medical Education in the condition investige 6 Could not determine the condition in th	a	and to death but the best of t	Due to (or as	onot enter the	of): of):	yen in Pert 26. Plac her: 42 Nr. hy at hy en, dete er hopinion, dec	e of Deeth ursing Hol	23b. Did 1 24a. Was period of the control of the co	tobacco use c Yee 2 No s en eutopsy ormed? Yes 2 No one) idence 6 0 how injury occu (Street and Num wm, State)	ontribute to 3 Proi	Approximete Interval Between Onset and Death Onset of Cause of Cause Onset
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State of Maryland / Department of Health and Mental Hygiene

					,	Cert	rificate of	Death	R	eg. No. 9 9) Ly	0565
	Di		1. Decedent's Name (First, Middle, La	st)					2. Date of Deal Month	th Day	Year	3. Tima of Death
N.	Physicia /Medic		WARD W. ALBRIG	HT					DECEMBE	_		9:20 AM
	Examin		4a Facility Name (If not institution, given					4b. City, Town, or Lo		4c. County		
			SACRED HEART H	OSPITAL	**			CUMBERL	AND	ALLE	EGANY	<i>[</i>
	Funeral Director		218-16-3754	Sex 7.Ag	e (In yrs. I 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day APRIL	Year)	Couin	lace (State or Foreign try) ARYLAND
	Ď ,		Usual Residence of Decedent 10a. State 10b. County		10- 03-	, Town or Loc	ation				1.	Od Incide Other Lieute
	anyle ehon	-					ation				1	0d. Inside City Limits 1 ☐ Yas 2 🛣 No
	N PER	Director		GANY	LA	VALE						
	1 6 2	듬	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	√hat Coun	try?
	£ 23		10307 CASH VAL					502		USA		
	e E	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. W	as Decedent of I Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, o	
21215-0020	and and	P	Millowed 4 Divorced	If Yes, Give Year or Dates:	No	11	☐ Yes 2 🗷 No	Specity:		Specify	· WH]	LTE
5-0	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give k	ent's Usual Occup ind of work done	during most of work	ing	16b. Kind of Bu	siness/Ind	lustry
21	E E	후	Elementary/Secondary (0-12)	College (1-4or !	+)		O NOT use retire	d)				
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ņ	T T T T T T T T T T T T T T T T T T T	B	17. Father's Name (First, Middle, Last					18. Mother's Nam				CD.
× ×	Men	2	WILLIAM F. ALB	RIGHT				PEARL F	LUKENC	E CHIL)FOI	Ł K
Maryland	2 sh end eum		19a. Informant's Name/Relationship	**				and Number or Rur				
	end eelth 727 74 to		TOM TACCINO/FR	TEND	J			VALLEY				
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Heelth and Mentel Hygiens. Important: If item 27 is marked other than any injury or other treumatic event, the Magnes.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	ace of Dispos emetery, crem	ition (Name of etory or other ple	ce) DEC 9.	1999	20c. Location -	City or To	wn, Stata
E	Pag ant: ury	1	4 Donation 5 Other (Special					RIAL GAR		LAVALE	E, MD	
alt	Semili.		21-Signature of Funeral Service Lice	nsee		22.	Name and Addre	ss of Facility APEL OF	TUE DI	TTC MC	ודיםו	ADV
Ш	89 E 2 8		Done Our	Hale)			IONAL HE				
1			23a. Part1. Enter the discussion, or comshock, or heart failure. List only	plications that caused one cause on each li	the death						1	Approximata Intervel Between Onset end Death
	Physician .		Immediate Cours (Final								1	Criser and Deam
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	SE	PTIC	SHI	CK			;	1 DAY
	3 2 300	=	rosuming in doubly			as a consequ					l l	
	D #	흵		b	14	ITE	PYELO	NEPHRITIS			İ	3 DAYS
	and Fran	Examiner	Sequentially list conditions,	-	Due to (or	as a consequ	ence of):	, , , ,				/
60,	cien cien	삘	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s5	EVER	EH	TYPO PROTE	INEMI A	_		i	6MONTHS
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	e et	8	Part II. Other significant conditions of	contributing to death b	ıt not resu	ilting in the und	derlying cause gi	en in Part I.	23b. Dld 10	obacco usa co	ntribute to	the cause of death?
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Records,	v require been si ahouid I	Completed							24a. Wes a perform		ava	ere autopsy findings ailable prior to
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of VItal		Be	25. Was case referred to medical					26. Place of Deal	th (Check only or	ne)		
>	0 0	2	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 201	ER/Outpatient	3 DOA Ot	ner: 4 Nursing Ho	ome 5 Resid	ence 6 Oth	er (Specif	y)
	d die		27. Manner of Death 1 DNatural 5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe h	ow injury occur	red	
0	Attending or death. ector: After by the fune	뚩	2 Accident investigation			,,		Yes 2□No				
Division	after death. Director: After	흹	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inj			et, factory, office		28f. Location (S City or Tow	treet end Numb	er or Rura	Il Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pt	ysician: To the best oniner: On the basis of	of my know	viedge, death	occurred at the ti	me, date end place,	end due to the c	ause(s) end me	enner es s	iated.
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eth)	within 2 To the comple	Σ	29b. Signature and title of continue	18/242			29c. Licens			9d. Date signe	d (Month,	Day, Year)
	10		D13/24	MD			D -	23334		DECEM	BER 6	也 1999
		-	30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, P	1-0					
	ne		D. SHAH, M	D., 6.	25-1	GN7 A	NENUE,	CUMBERS.	and, r	10 215	25	
	Stat	e .	31. Date filed (Month, Day, Year)	32. Registr	ar's Signal	ture	,					
	Registra		DEC 0 8 1999	Sen	~	5 A	book					

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey **Physician** 4b. City, Town, or Location of Death 4c. County of Death 0450 a.m Louis Emmett Albright /Medical 4e Facility Name (If not institution, give street and number) Examiner Cumberland
If Under 1 Year | If Under 24 Hrs. Sacred Heart Hospital Hospice 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 100 M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Yrs. Director 217-28-2451 01-Jul-29 Maryland Usual Residence of Decedent 10s State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits ahom forms 23s or 28s-f short four must be notified at 1 Yes 2 No Director Maryland Allegany Frostburg the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 17508 Pompey Smash Road, S.W. Funeral 14. Rece - American Indien, 21532-12. Was Decedent Ever in U.S.
Armed Forces?

1 12 Yes 2 No Kor ear
If Yes, Give
Year or Dates: Con Flict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status pernit. Pages 1 and 2 should be filed within 72 hours aftar d Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor. service station Baltimore, Maryland 17. Fether's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surneme) James Marshall Albright Myrtle Fatkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Nerrie of cemetery, crematory or other place)

1.7508 Pompey Smash Road Frosburg
Date Arlene Albright 20a. Method of Disposition Wife Maryland 21532-20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removat from State 4 □ Donation 5 □ Other (Specify) Vale Summit Methodist Cemetery 10-Dec-99 Vale Summit, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility John K.K uce Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23s Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** puncicas motastutic Adenoxacinona Immediate Cause (Finel disease or condition resulting in death) 07 /Medical Examiner 64195 Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown diabetes , page 2 should be defi-Records. 24b. Were autopsy findings available prior to completion of cause Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Hospital or Attanding Physician: 124 hours after death.
 Funeral Director: After this carifical leigh filled in by the funeral director, p. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitet: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only To the Within 2 29b. Signature and title of outline 29c. License number 29d. Dete signed (Month, Day, Year) 021488 10 December who completed cause of death (Item 23a) (Type, Print) 20 Dougles Ave., Conaconing, evin my nomus 32. Registrar's Signature State Registrar

State of Alberta

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PRES 8 to July

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 40567

			Ce	rtificate d	of Death		Reg. No.	
Dhualaian	1. Decedent's Name (First, Middle, I	Last)				2. Date of D Month		Year 3. Time of Death
Physician /Medical	DONALD	ANDREW	AMO	RUSO			ER 10. 1	
Examiner	4a Facility Name (If not institution, g			1 198		wn, or Location of Dea		of Death
	Sacred Heart	-				erland		Allegany
uneral	5. Social Security Number 212-38-5335	Sex 7. Age (I	In yrs. last birthday 6.1 Yrs.	If Under 1 Ye	ear If Under a	Min (Month I)	15, 193	9. Birthplace (State or Foreign Country) WV
ector	Usual Residence of Decedent	Λ	61 Yrs.			Aug	10, 193	O WV
Director	10a. State 10b. County	11	Oc. City, Town or L	ocation				10d. Inside City Limits
o p	MD All	egany	Cı	mberla	and			1 Tyes 2 □ No
Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of V	Vhat Country?
la D	14704 Viewcre	st Road			215	502	USA	
Funeral	11. Marital Status	12. Was Decedent Eve	or in U,S. 13.	Was Decedent	of Hispanic Orig	gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Rac	e - American Indian,
F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 40 If Yes, Give		1 Yes 2		, rueno rican, etc.)		k, White, etc.
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		12100 22	Co opeany.		Зреспу	white
Completed	15. Decedent's (Specify only highest of	Education rade completed)	(Give	dent's Usual Oc kind of work do	one durina most	of working	16b. Kind of Bu	usiness/Industry
E	Elementary/Secondary (0-12)	5 + College (1-4or 5+)	Teac	DO NOT use re	tired)		College	
ပိ	17. Father's Name (First, Middle, La.	۵,	reac	MCI	18 Mathe	r's Name (First, Middle		
Be C	Andrew Joseph						McCorm.	
2	19a. Informant's Name/Relationship		10h Meil	ing Address (St		r or Rural Route Numi		
	Mary Lou Amor		1470	4 Viev	crest	Road; Cun	berlan	d MD 21502
	20a. Method of Disposition		20b. Place of Disp	osition (Name o	1	Dete	20c. Location -	City or Town, State
	1 Desuriat 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	treates.	metory or other		10/11		1 100
Succession	21. Signature of Fueeral Service Lio					neral Ho		
	I A Salah Silve	1 100 100	10/2	_		Maryland		
	23a Part Enter the disease or re	mulications that counted the	death Do not or					Approximete
ian	23a. Pert 1. Enter the disease, or conshock, or heart failure. List on	y one cause on each line.	3 300 11. 50 1101 01	10 110 11000 01	oying, adoir do t	our old or respiratory	arrest,	Intarval Between Onset and Death
al	Immediate Cause (Final	Make-	-4. 10	· · no.lo	- 161 1	6	1-11	18 month
er	disease or condition resulting in death)	a. Integrasia	e to (or as a conse		come;	Tarnor o	11100	184116
è		00	e to (or as a conse	querice or):				
Examiner	Sequentially list conditions,	b	e to (or as a conse	quence of):				
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
VMedical	that initiated events resulting in death) Last	C. Due	to (or as a conse	quence of):				
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Se S		d						
Physician	Part ft. Other significant conditions	contributing to death but n	ot resulting in the	inderlying cause	given in Part f.	23b. Dio	tobacco use cor	ntribute to the cause of death?
						1	Yes 2 No	3 Probably 4 Unknown
þ								
Completed	ALL A TOP						s an autopsy ormed?	24b. Were autopsy findings aveilable prior to completion of cause
E G								of deeth?
						10	Yes 20 No	1 ☐ Yes 2 ☐ No
Be	25. Wes case referred to medical examiner?	Manager				of Death (Check only	one)	
2	1 Yes 2 100	Hospitat:	2 ER/Outpatie			rsing Home 5 Res		
on	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o		njury et Work?		how injury occurr	ed
tification:	2 Accident investigati 3 Suicide 6 Could not	he	A14		1 Yes 2 N		(Chan at a and this as h	B I B t - N t -
Certification:	4 ☐ Homicide determine	28e. Place of Injury building, etc. (\$	- At nome, tarm, st Specify)	reet, tectory, off	Ce		(Street and Numb ewn, State)	er or Rural Route Number,
Medical Ce	29a, Certifier 12 Certifying P	Austrian Verte have a second						
edicai		hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in	vestigation, in n	ny opinion, deat	place, and due to the h occurred at the time	cause(s) end me , date end plece, (nner as stated. and due to the cause(s)
¥	29b. Signature and title of certifier	A //	7	29c. Lic	ense number		29d. Date signed	i (Month, Day, Year)
0	1/4	6/0/	111	7) > -	-135		
	30. Name and address of person wh	CAVO	1///	2	155	-135	DECEMBI	ER 1999
W	The man e	Can Cause of death	A /// Do	D A	17 501	on Dr.	Min	herland in
tate	31. Date filed (Month, Day, Year)	32 Registrar's	Signature /	0 11	2000	00-	(67 17	Drijatioj VID
istrar	31. Date filed (Month, Day, Year) DEC 13 199	3 Spens	19	Spork	1			ACTION YOUR

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			and / Depart <i>Certi</i>	ficate of			Reg. No.	9 40	568
Physician	Decedent's Neme (First, Middle, La.					2. Date of Dea		Year	3. Time of Death
/Medical		ELEN REBECO	CA BARBE	R		December	er 10	1999	08:10 PM.
Examiner	4a Fecility Neme (If not institution, giv	e street end number) 09 East Main	Street		4b. City, Town, or Westmin:			y of Death ROLL	
Superal	5. Sociel Security Number 6. S			If Under 1 Year					a (State or Foreign
Funeral Director		□M 2X7 F 8 €		Months Days	Hours Min	8. Date of Birt (Month, De 6/30/	r, Year) 1913	MARYL	AND
Hygiene. ther than "netural", or items 23s or 28s-1 show int, the Medical Examiner must be notified at the Completed by Funeral Director	10a. Stete 10b. County	10c.	City, Town or Local	ion					Inside City Limits
23a or 28a-f shower that the months of all the months of all the color	MD. CARROL	L V	VESTMINS	TER					1 ☐ Yes 2 No
or 2 be no	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	7
eral	409 EAST MAIN	ST. 12. Wes Decedent Ever in	116 12 140	2115		Pageity Van av Na	USA.	ce - American	todion
it, or items 23s parties must by Funeral	11. Maritel Stetus 1 Never Merried 2 Merried 3X Widowed 4 Divorced	Armed Forces? 1 Yes 2\ No If Yes, Give Yeer or Detes:		es, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		ck, White, etc.	
	15. Decedent's Ed	lucation	16a. Deceden	t's Usuel Occu	pation		16b. Kind of B	usiness/Indus	lry
it, the Medical Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give kin	d of work done NOT use retire	pation during most of wo d)	orking			
Con	2			OWNER			RESTA	URANT	
To Be	17. Fether's Neme (First, Middle, Last) DAN	IEL OSCAR S	SUMMERS		18. Mother's Ne	me <i>(First, Middle,</i> RIE	<i>Maiden Sumai</i> MAY	ne)	
EE	19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing	Address (Stree	t and Number or R	ural Route Numbe	r, City or Town	, Stete, Zip Co	de)
other tra	JOHN THOMPSON	- SON			ST., WI				
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐		 Plece of Dispositi cemetery, cremet 	on (Neme of ory or other ple	ice)	Date	20c. Location	- City or Town,	Stete
Jury	4 ☐ Donetion 5 ☐ Other (Specifi		DDLETOW						
important: If it eny Injury or one	21. Signeture of Furnital Service Licen	See			AIN ST.				
burial-transit and transit and	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	o (or as e consequen	nce of):	vascular	Disea	Se		
Physician/Medical	Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	Due to	(or es e consequer	nce of):					
hed for	Part II. Other significant conditions of	ontributing to death but not i	resulting in the unde	orlying cause gi	ven in Pert I.	23b. Dld t	obacco use co	entribute to th	e cause of death?
oy Phy						101	fes 2□No	3 Probab	ly 4 Unknown
page 2 should be datached Completed by Physic						24e. Wes perfor	an eutopsy med?	eveila	autopsy findings ble prior to etion of cause th?
sage 2						101	es 28 No		es 2 No
rector, page Be Co	25. Wes case referred to medical				26. Place of De	eth (Check only o	ne)		1 -11 - 1
this ceral direct	examiner? 1/12 Yes 2 □ No	Hospitel: 1 Inpatient 2	ER/Outpatient	3 DOA O	her: 4 Nursing I	Home 5 AResid	ence 6 🗆 Ott	ner (Specify)	
r: After the funeral ation:	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of tnjury	M 1 [ryat ⊮k?]Yes 2∐No	28d. Describe h	ow injury occur	rred	
of the Funder Director. After this certificate in completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - Albuilding, etc. (Spe	t home, ferm, street ocify)	, factory, office		28f. Location (S City or Tow		ber or Rural R	oute Number,
pletely fill edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	reician: To the best of my k linar: On the basis of exami end menner steted.	nowledge, deeth or inetion end/or inves	curred at the ti	me, date end place opinion, deeth occ	e, end due to the durred et the time, d	cause(s) and m date end piece,	anner as state end due to the	d. e cause(s)
To th	29b. Signeture and title of cartifier	001		29c. Licen	se number		29d. Date signe	ed (Month, Day	r, Year)
	Denne	& Chuetin		0	C.M.E.		Decemb	per 11.	1999
	30. Neme and address of person who of Dennis Chute M.D.	· ·		nt)		Baltimore		1.00	
	Dunial Cinice II.D.			LLCHII	JULICUL, I	ALL CHINTS	I I'MOLL V	LCILLI Z.	201

DEC 1 1999 James & Marky

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Tima of Deeth Month 7:15 PM Margaret Lee Daniel December Barnes 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Carroll County General Hospital Westminster Carroll 7. Age (In yrs. last birthday) 80 Yrs If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foraign Country) N.C. Months 1 □ M 200 Days Hours 245 09 3588 Sept. 25, 1919 Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 21784 U.S.A. 7200 Third Ave. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 11. Maritel Status Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas ZENo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Domestic 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Adolphus Leland Daniel Maggie Winburn 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Sylvia D. Gorman daughter 729 Uniontown Rd. Westminster, Md. 21158 20a. Method of Disposition 20b. Place of Disposition (Nema of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramovel from Stata 12/11/99 Old Oakland Cemetery Sykesville, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Name end Addrass of FacilityHaight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784 23a. Partt. Enter the disaasa, or compilections that caused tha daath. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or head failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath Immadiata Causa (Final disaasa or condition rasulting in daath) Due to (or as a consequance of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings eveileble prior to complation of cause of deeth? 24a. Was en eutopsy performed?

Physician /Medical Examiner

physician and s the burief-transit

ettending p

signed by the e

certificate hes been si irector, page 2 should l

funeral

After

Hospital or Attending 24 hours efter death. Funeral Director: Afte

To the Hospital or Atter within 24 hours efter det To the Funeral Director completely filled in by th

law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Attending Physician: Examiner

Physician/Medical

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Completed

Certification:

Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

Be

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Funeral

Director

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be or

natural, or

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other traumatic event, atics.

Moracht Lee Barnes

Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disaasa or injury that initiated evants rasuiting in daath) Last

1 🗆 Yas 26. Place of Deeth (Check only ona)

1 ☐ Yas 2 ☐ No

25. Was cese referred to medical				
axaminar? 1□ Yas 2□ 10	Hospitai:	2 □ ER/Outpationt	2□ DOA	Ot

1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b Time of

ther: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28c. Injury et Work? 1 Yas 2 No

28d. Describe how injury occurred

2 Accidant 6 Could not ba 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Spacify) 4 - Homicide

28f. Location (Straat and Number or Rurel Routa Numbar, City or Town, Stata)

1 Cartifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and menner as steted.
2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and title of certifier

27. Manner of Death

1 Naturel

29a, Cartifier

29c. Licansa number

29d. Date signed (Month, Dey, Year)

30. Name end eddrags of person who/completed causa of daath (Itam 23a) (Type, Print)

Business

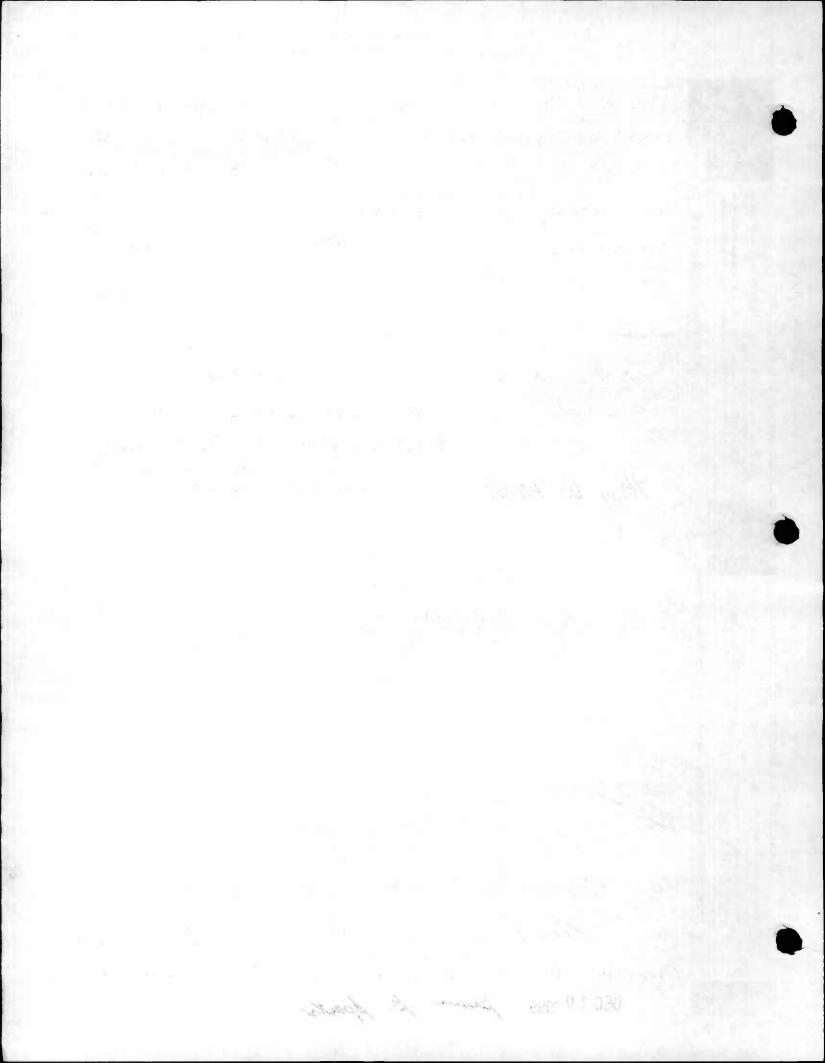
enter Drive Reistratown, MD

State Registrar 31. Data filed (Month, Day, Year) DEC 10

5 Pending

invastigation

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 40570 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month December 12:15 a.m. Rosalie L. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Mariner Health of Bel Air Bel Air Harford 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) Sept. 5, 1916 Maryland If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) Days 1 M 2 Yrs. 212-18-2091 83 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4028 Chapel Road 21078 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 202No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly line Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Lauterbach Anna Catherine Hoohlein 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Jo Ann Phillips (Niece) 4028 Chapel Road, Havre de Grace, MD 21078 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Baker Cemetery 12/14/99 Aberdeen, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Congo, 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate tntervel Between Onset end Deeth tmmediate Ceuse (Finet diseese or condition resulting in death) Cardiovascular disease sclerotic Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

certificete be executed

BODE, KOSALIE

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

MD

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Merylen Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumetic event, the Medical Experies must be notified at once.

Baltimore, Maryland 21215-0020

Examiner ettending physician end I for use es the buriel-transit Physician/Medical

þ Completed Be

tor: After this certificate has been signed by the eithe funeral director, page 2 should be deteched in

To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the

after death Director: /

Certification:

4 Homicide (Check only one)

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Yeer)

DEC

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Sulcide

29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

3 1999

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation Injury

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 45Nursing Home 5 Residence 6 Other (Specify) 28c. tnjury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dev. Year) 29c. License number d 35522

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark

NORTH

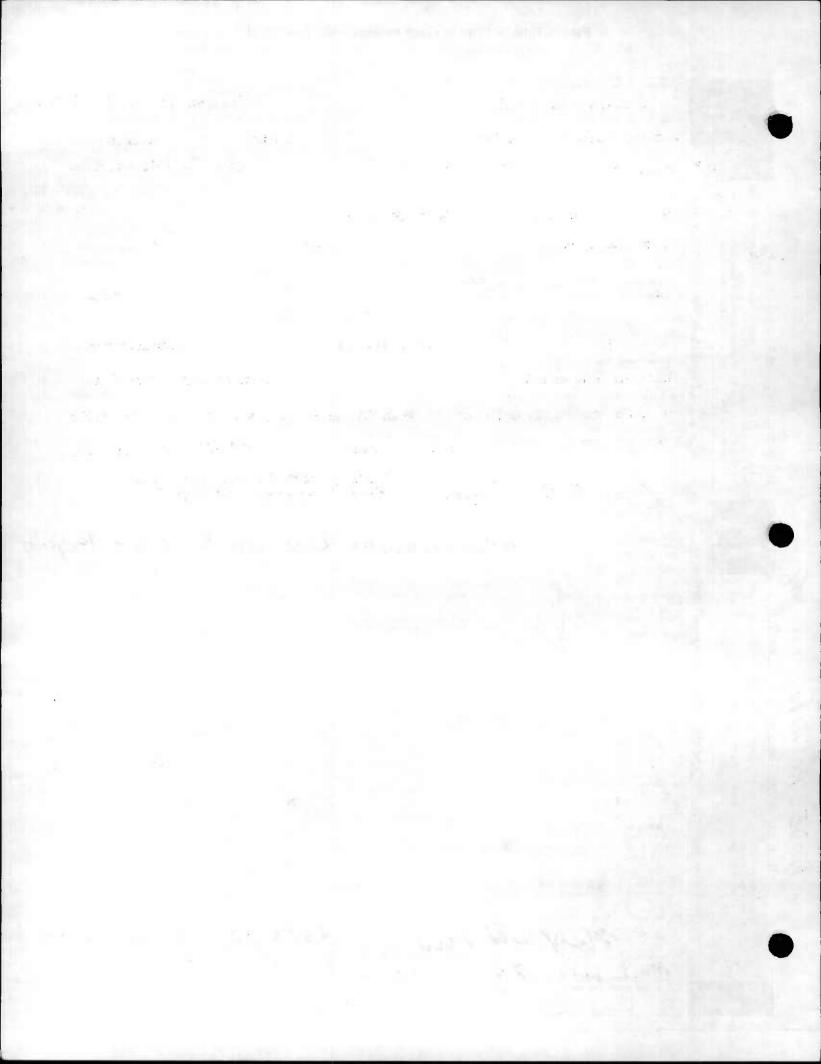
Bel Air Maryland 21014.

Avenne 32 Registrar's Signature

Registrar

Medical

DHMH 16 Rev 6/95

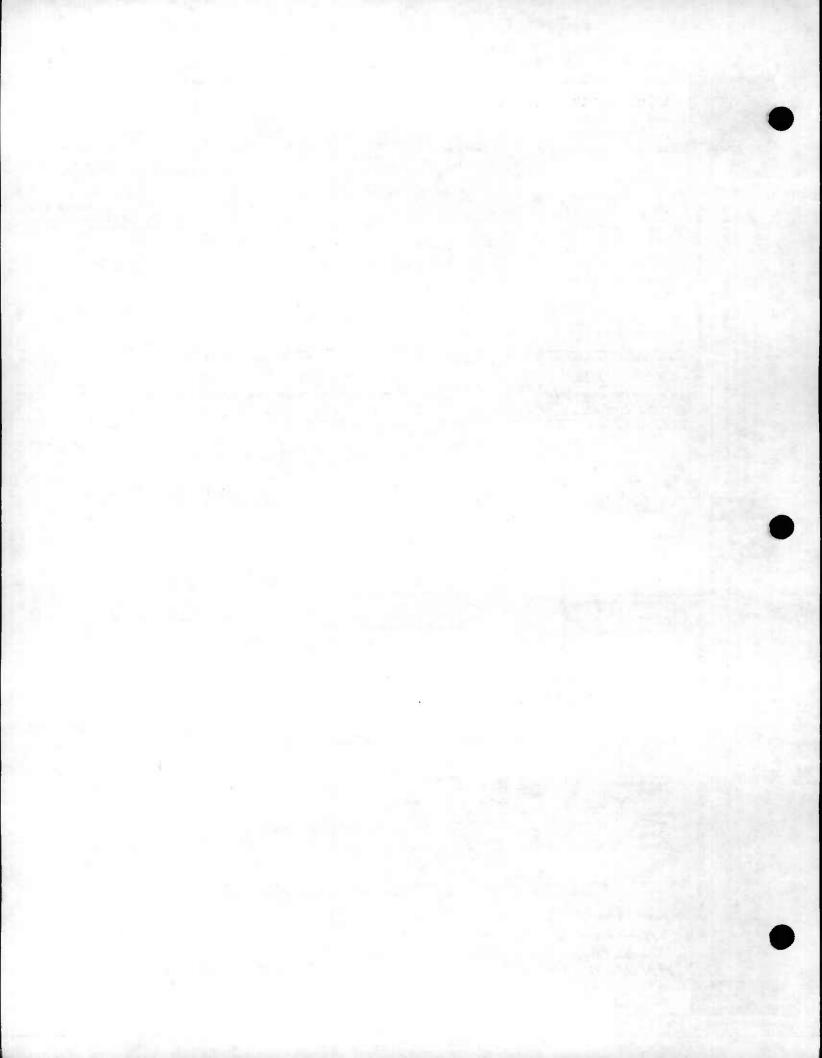


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dhusisian	1. Decedent's Neme (First, Middle, Las	()		rtificate of	20011	2. Date of D Month	Reg. No.	3. Time of Death				
Physician /Medical	Helen Dorothy					Decem	her 9 1	999 20 999 pm				
Examiner						or Location of Dea						
1	Fallston General	-		If Under 1 Yea	Falls			ford				
Funeral Director	5. Social Security Number 6. S. 025-07-3250	7. Age (In yi	s. last birthday, Yrs.	Months Days		Ain. (Month, D	lay, Year)	9. Birthplace (State or Foreign Country) Massachusetts				
Mand Mand	10a. Stete 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits				
Mary Mary Mary Mary Mary Mary Mary Mary	Maryland Harford	1	Bel	Air				1⊠Yes 2□No				
n with the Maryla 3a or 28a-f shor at be notified at		_e		10f. Zip Code 210)14		10g. Citizen of V					
Maryland 21215-0020 d 2 should be filed within 72 hours after death in the and Mental Hygiene in Tathural, or harms 23a traumetic event, the Medical Examinar must To Be Completed by Funeral	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		Was Decedent of if Yes, specify Cu		? (Specify Yes or Nuerto Rican, etc.)	o- 14. Rac Bled Specify	e - American Indian, ok, White, etc. White				
72 hz 72 hz 72 hz	15. Decedent's Ed (Specify only highest gra-	ucation	16a. Dece	dent's Usuat Occu	pation	working	16b. Kind of Br	usiness/Industry				
I 21215-0 led within 72 ho typiene. We then 'netur it, the Medical. Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	ed)							
Cor the Cor	17. Fether's Neme (First, Middle, Last)	1	H	<u>iomemaker</u>				Home				
Be sver		10.1 com				Name (First, Middle						
hould d Men marks marks	Edward Julius N 19e. Informent's Neme/Retetionship (7)		10b Mail	na Addrage /Stee	-	Miltilda Rural Route Numi						
Ma dd 2 s dd 2 s dd 2 s dd 2 s	Ann D. Barber - Da					l Air, Ma		21014				
re, Hear 2 other	20e. Method of Disposition			osition (Name of matory or other pl	-	Dete	-	City or Town, State				
altimore, mit. Pages 1 a portant: if liem y Injury or othe	1 XBuriel 2 Cremetion 3 4 Donetion 5 Other (Specify	Lieutovet Itotti Stefe				ry 12-12-	99 Jopp	a, Maryland				
Ball permit permit import impo	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Marylan											
Physician	23a. Pert V. Epfer the disease, or comp shock, or heert feilure. List only of	dications but caused the de one cause in each line.						yland 21009 Approximate Interval Between Onset and Death				
/Medical Examiner	Immediate Cause (Final disease or condition	9	SEPS	15				10DAYS				
	resulting in deeth)	Due to	(or es a conse									
ne de company		b. BILAT	BRAL	PNE	UMON	14						
58760, icate be executed physician and sthe burial-transit		Due to	(or es e conse	quence of):								
death certificate be as a standing physician of for use as the buriant sician/Medical E	that initieted events resulting in death) Lest	c. Due to	(or es a consec	quence of):								
1 E E E		d										
Box leath car attendir for use												
P.O. BOX	Part II. Other significant conditions co		esulting in the u	inderlying cause g	iven in Pert t.			ntribute to the cause of death?				
	THENT	BNSION				_ 1	Yes 20 No	3 Probably 4 Unknown				
cord requir should should						24a. Wa	s an eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?				
The la						10	Yes 2 No	1 ☐ Yes 2 ☐ No				
/ital	25. Wes case referred to medicat				26. Place of	Deeth (Check only	1412					
Of Vita Physician: this certific ral director,	examiner? 1 Yes 2 No		☐ ER/Outpatie	nt 3 DOA	ther: 4 Nursin	g Home 5 Res	sidence 6 Oth	er (Specify)				
Vision of Attending Plur death. octor: After the by the funeral iffcation:	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury		ury at ork? □ Yes 2 □ No	28d. Describe	how injury occur	red				
Cert Cert	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec				er or Rural Route Number,						
he Hospital in 24 hours he Funeral pietely filled edical Co	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicat Exam	sician: To the best of my ki iner: On the basis of exami- and menner steted.	nowledge, deat netion and/or in	h occurred et the t vestigation, in my	time, date and pl opinion, deeth o	ace, and due to the courred at the time	cause(s) and ma , date end plece,	nner as stated. end due to the cause(s)				
within 2 To the comple	29b. Signeture end title of certifier		7 1		nse number			d (Month, Day, Year)				
	Andw No	walund	- m		080	96	DESM	BER 9, 1999				
10	30. Name and address of person who can be also address.	ompleted cause of death (It	em 23a) (Type,	Print)	5 N/	CAIN ST.	BELA	MP, MD 21014				
State Registrar	31. Dete filed (Month, Day, Year) DFC 1 0 100	32. Registrer's Sig	nature &	do	1							

DHMH 16 Rev 6/95

BarberiHden



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 0 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER **Physician EMMA** KATHLEEN 1999 10:45AM BURCH 14 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 3, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F 215-36-5581 Director Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show the Medical Examiner must be notified at MD Charles La Plata 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 10200 La Plata Road 20646 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas No If Yas, Give 14. Race - American Indian, Black, Whita, atc. Heme Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Nevar Married 2 Married 'natural', or 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home other 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be fill iment of Health end Mentel Hilant: If Item 27 is merked oth Be Connulis Morgan Frances Knott Morgan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 Is m any injury or other traum page. Cynthia Olmsted/Guardian 8190 Port Tobacco Rd. Port Tobacco, MD 20677 20a. Nethod of Disposition
12 Burial 2 Cremation 3 Ramoval from State 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Othar (Specify) Trinity Memorial Gar: 12/20/99 Waldorf, MD 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility AREHART-ECHOLS FUNERAL HOME, PA P.O. MO945 BOX 567 LA PLATA, MD 20646 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailura. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in death) 2 mas Examiner Due to (or as a consequence of): Physician/Medical Examiner the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or Injury The law requires that the death certificate be execu Box 68760. that initiated evants resulting in death) Last Due to (or as a consequence of): USB as ettending for usa as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy lindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physician: 24 hours after deeth. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yas ay No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpetient 3 DOA this 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation To the Hospital or Attendition within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accidant 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify) 4 Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedlcat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) DEC 16 1999

PAUL E. PRITCHETT M.D.

29b. Signature and titla of pertifie

32. Registrar's Signature Genera

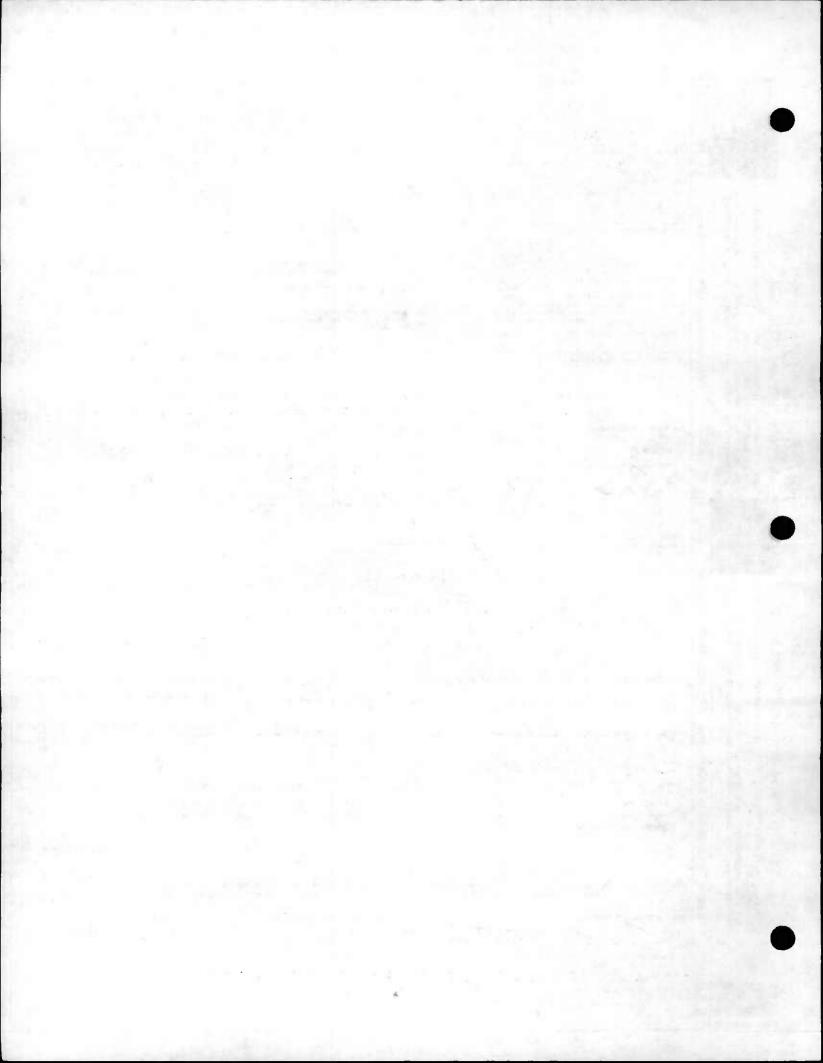
30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

118 LAGRANGE AVENUE LA PLATA MARYLAND 20646

29c. License number

D-08370

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey 5, **Physician** 1999 03:20 A.M. JULIA FRANCES BUDRIES DECEMBER /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Sacred Heart Hospital Allegany Cumberland If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2√F Months Hours 77 219-14-5693 Director Aug. 11, 1922 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Md Allegany Cumberland 1 ☐ Yes 200 No Director 23a or 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 941 Bishop Walsh Rd. 21502 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after despendent of Heath and Mental Hygiens. Important: If Item 27 is marked other item. See any injury or other transmitted other increases. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give or Reme Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Year or Detes: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Health Care 12 Licensed Practical Nurse 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Budries Frances Rushaldie 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Helen Calemine / Sister 12310 Upper Georges Creek Rd. Frostburg, MD 21532 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 12/7/99 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 111 Church Street Boal Funeral Home Westernport, MD 21562 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical ulery Examiner Due to (or as e consequence of) Physician/Medical Examiner The lew requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last burial-tran Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, the Due to (or es a consequence of): for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown À 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? certificate hes 2 7440 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Weturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, tectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted. 29a. Certifier (Check only one)

State Registrar

DHMH 16 Rev 6/95

29b. Signeture end title of certifier

31. Date filed (Month, Dey, Year)

DEC

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

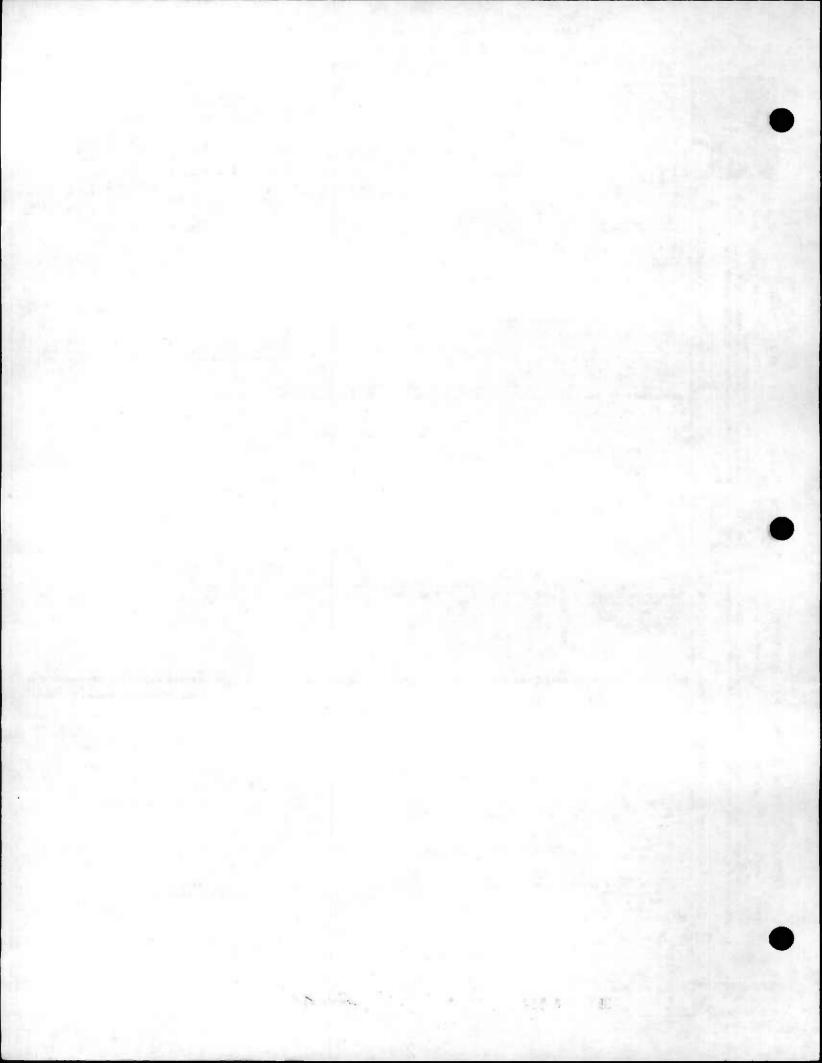
George M. Breza MD 912 Seton Drive, Cumberland, MD

32. Registrar's Signeture

29c. License number

2532

29d. Date signed (Month, Day, Year) 9



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		1. Decedent's Nem	e (First, Middle, La	ast)								2. Date of De				3. Time of Death	
	Physician	CLIFTON L. BENNETT										Month DECEMI	DECEMBER 11,1999			5:50PM	
	/Medical Examiner	4a Facility Name (If not institution, give street and number)								b. City, Town	n, or Lo	cation of Deat			of Deeth		
	exumino.	BERLIN NURSING HOME								BERLIN			WORCEST				
	Funeral Director	5. Social Security Number 199–28–4445 6. Sex 1						If Under 1 Y Months D	ear ays	If Under 24 Hours	Hrs. Min.					e (State or Forei RE	gn
170	9	Usual Residence of			1												
2	ossen with the Maryand res 23s or 28s-f show Linust be notified at heral Director	DELAWARE	10b. County SUSSEX		10c. City, Town or Location DAGSBORO										Inside City Limit 1 ☐ Yes 2 🔀 N		
3	or 28a-fa be notified	10e. Street and Nur	mber		<u></u>			10f. Zip Co	de				10g. Ci	itizen of \	What Country	?	
	238 c	RD#2 BOX	128			•		1993	939 USA								
	ar. or he Examine by Fur	11. Marital Status 1 Never Merri 3 Widowed	ied 2 Marrled 4 □ Divorced	Armed For 1 ☐ Yes If Yes, Gi	1 TYPE 2 TYNO			as Decedent of HispanIc Origin? (Spec Yes, specify Cuban, Mexican, Puerto R □ Yes 2 X No Specify:			Rican, etc.) Black, W		e - American ck, White, etc	umerican Indien, Vhite, etc. WHITE			
,	natural disal	(Spec	15. Decedent's E	ducation	etion 16a. Decedent's Usual (completed) (Give kind of work)			nt's Usual O	Occupation done during most of working			na	16b. Kind of Business/Indus		try		
21213-0050	ygene. We then "natur To the Medical. Completed	Elementary/Seco			College (1-4or 5+)				etired) FARMER			FARMING					
0	1 2 2 0	17. Father's Name (First, Middle, Last)							18. Mother's Name (First, Middle, Maiden Sumame)								
	Menta Menta affic en To B	LONNIE T. BENNETT							BEATRICE STAFFORD								
	ama aman	19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta								State, Zip Co							
70.00	and n 27 m 27	ELIZABETH BENNETT/WIFE RD#2 BOX 128, DAGSBORO, DELAWARE, 19939															
	nt: If lien	1 X Burial 2	20a. Method of Disposition 1 \(\text{M Burial } 2 \subseteq Cremation } 3 \subseteq Removal from State \) 4 \(\text{Donation } 5 \text{Dother (Specify)} \) 20b. Place of Disposition (Name of cemeler, crematory or other place) \) ST. GEORGE \(\text{S CEMETERY} \) 12-15-9 \(\text{CLARKSVILLE}, \text{DELAWARE} \)												E		
	Departm Departm Imports any inju	22. Name end Address of Facility MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST., FRANKFORD, DELAWARE. 19945											3.6				
	will	23a. Part1. Enter to shock, or hee	he disease of com rt failure only	plications thet one ceuse on o	caused the eech line.	death. Do no	ot enter	the mode of	f dyin	g, such as ce	erdiac o	or respiratory a	rrest,		: In	oproximate tervel Between	
F	hysician /Medical	Immediete Cause (Final		1				/	0					0	nset and Death	
١	Examiner	diseesa or condition resulting in death)	n	a					1	100	1 K	noni	人	14	12	un-	
	ğ l			•	Due	to (or es a co	onseque	ence of):							1	•	
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	attending p for use as clan/Mee			d											<u> </u>		_
	sed fo	Part II. Other eignif	Icant conditions	contributing to d	leath but not	t resulting in	the und	lerlying caus	e give	en in Part I.		23b. Did	tobacco	o use co	ntribute to th	e cause of deat	h?
	untas met the beauth bent is signed by the attending id be detached for use a d by Physician/M	An	Ten	iosc	lei	vos	15	D.f	11	vice	-	10	Yee :	2 N o	3 Probat	aly and unkno	win
Spinosulas,	been s should	Buterios clevos is Poffuse 1 Yee 2 No 3 II Co Long Cuttery Districe 24a. Was an autopsy performed? 24b									availa	autopsy findings ble prior to letion of cause ath?					
	page 2						`					10	Yes 2	K No	1 D Y	es 2 No	
	entifice octor, p	25. Was cese refer	red to medicel							26. Place o	of Death	Check only	one)				_
-	this certific rel director, TO Be (exeminer?	No	Hospital: 1 🗆	Inpatient	2 ER/Out	patient	3□ DOA	Othe	The same of the sa		me 5□Resi		6 □Oth	er (Specify)		
	after death. Director: After this certificate he in by the funerel director, page ertification: To Be Com	27. Manner of Deati	h 5 Pending investigatio	28a. Date (Mon		28b. Ti			Injun Work		2	28d. Describe					
	is after death. In Director: After the din by the funeral Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place	e of Injury - i	At home, ferr	m, stree	et, factory, of	ffice		1	28f. Location (City or To			per or Rural R	oute Number,	
	Funeral Direction of Secretary filled in Edical Certi	29a. Certifier (Check only one)	1K Certifying Ph 2 Medicet Exar	niner: On the b	best of my easis of exar ener stated.	knowledge, minetion and	deeth o	occurred at ti stigation, in	he tim	e, date and pinion, death	plece, a	and due to the ed et the time,	cause(s	s) end me ad place,	enner es state end due to th	ed. e ceuse(s)	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

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State Registrar 29b. Signature and title of ce

31. Dete filed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23¢) (Type, Print)

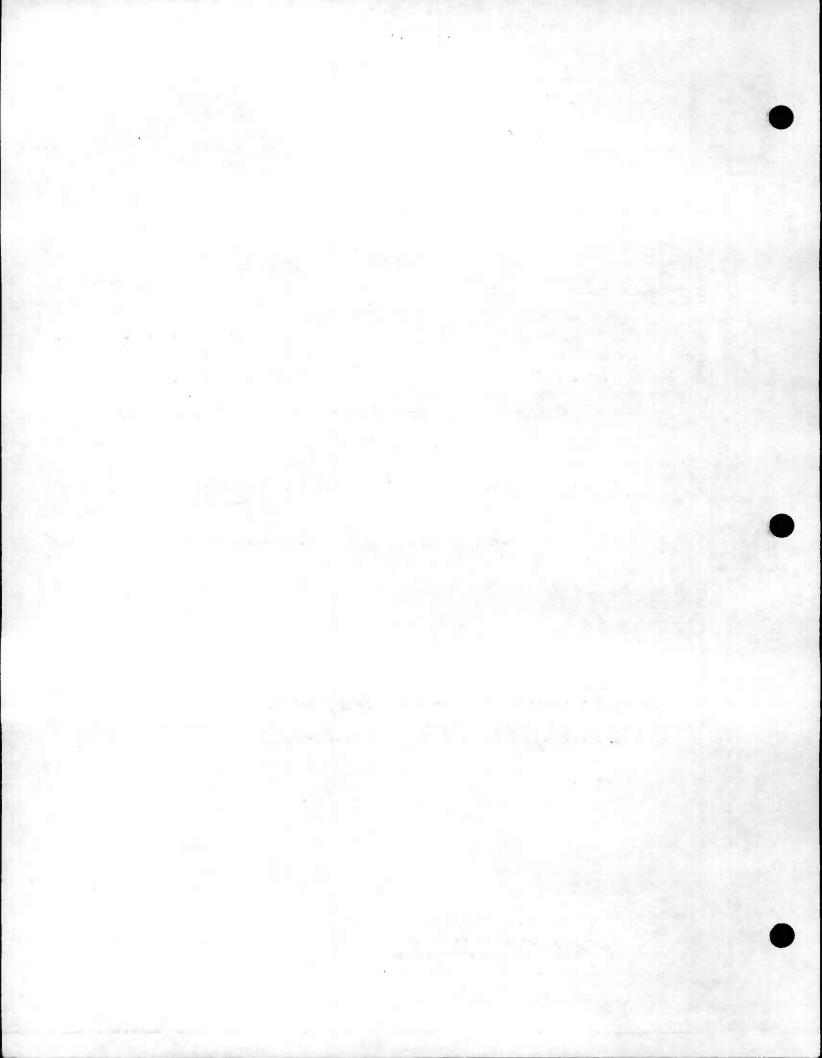
DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD.

29c. License number D02026

21811

29d. Date signed (Month, Day, Year)

410-641-4400



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 13 **Physician** 12 99 THOMAS MCDEVITT BENNETT 3:00 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Deys 11€ M 2□ F Yrs. Director MD 219-20-3749 3/17/27 Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 3 ☐ No MD Worcester Berlin Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 560 Ocean Parkway Ocean Pines 21811 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Serves 2 No If Yes, Give Yeer or Dates: 1945-47 1 Never Merried 2 Married 1 Yes 3√ No Specify: white by 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mantal Hygiana. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Survey Engineer State Roads Commission 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Sarah V. Staley Alton Y. Bennett 2 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 560 Ocean Parkway Berlin, MD 21811 Undine Bennett/ Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Cape Henlopen Crematory 12/13/99 Frankford, DE 22. Name end Address of Facility Burbage Funeral Home 108 William St. Berlin, MD Approximete Intervet Between Onset end Deeth hat caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Physician Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical Examiner Examiner attanding physician and for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) been signed by the a Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? cartificate has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. tnjury et Work? 5 Pending Investigation 1 Neturel ie Hospital or Attending n 24 hours aftar death. ie Funeral Director: Aft oletaly filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fund completely f (Check only one) 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 404 Brett Levy, MD 9733 Healthway Dr. Berlin, MD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

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DHMH 16 Rev 6/95

Registrar

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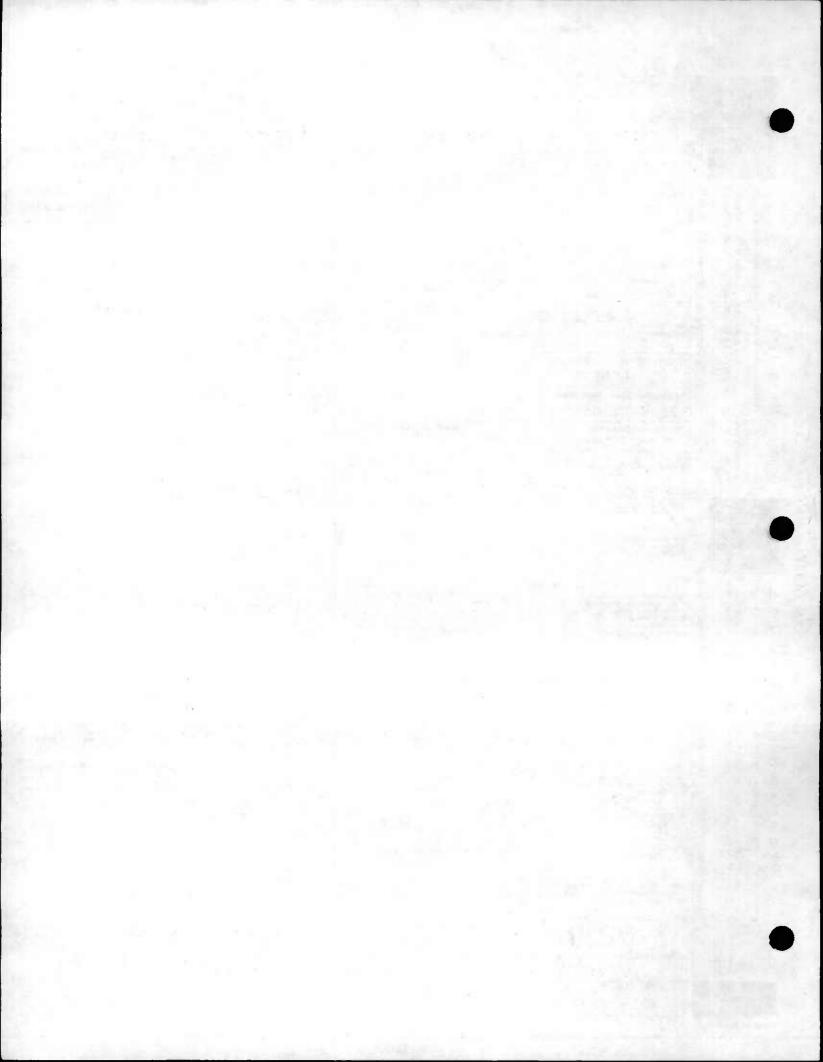
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0.1	Decedent's Nama (First, Middle, Last		Certificate of		Reg. No.	+0576	
Physician /Medical	GAYNELL	COLLINS		Month Dece	mber 12, 190	3. Time of Death 3. Time of Death	
Funeral Director	4a Facility Nama (If not institution, give Fallston Gene 5. Social Security Number 6. Sec	eral Hospita	1	Fallston If Under 24 Hrs. 8. Data o (Month) Hours Min. 9/22	Harfor	rd hhplace (State or Foreign country)	
Director	212-28-1540	10c. City,	Town or Location Whiteford	1 19/2.	2/1929 Mar	10d. Inside City Limits	
ath with the Mar 123s or 28s-f al 12st be notified 17st Director	10e. Street and Number 4425 Prosp			160	10g. Citizen of What C		
5-0020 72 hours after death with the Marylend natural, or itema 23e or 28e-4 show after Evandom must be notified at second by Funeral Director	11. Marital Status 1 Nevar Marriad **Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yas 217 10 If Yes, Give Yaar or Datas:	13. Was Decedent of H If Yes, specify Cubi 1 Yes 2XXIII	lispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc. Specify:	14. Race - Am Bleck, Whi	ita, etc.	
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hygiene. 7 Is marked other than "natural", or traumatic avent, its Medical Event traumatic avent, its Medical Event To Be Completed by F	15. Decedant's Edu (Specify only highest grade Elamantary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Homemaker	during most of working d)	16b. Kind of Business/Industry		
aryland should be filed should be filed in marked other umatic avent.	17. Father's Nama (First, Middle, Last) Lester Pl			18. Mother's Nama (First, Mic Leona Pool	le		
C 2 0 F	19a. Informant's Name/Ralationship (Ty Floyd F. Collin: 20a. Mathod of Disposition	s- husband	4425 Prospe	and Number or Rural Route No.		21160	
Baltimore, permit. Pages 1 at Department of Hee Important: If Item; any Injury or othe once.	1 Burial 2XX memetion 3 R 4 Donation 5 Other (Specify) 21. Signature Funaral Sarvice License	emoval from Stata Eva	metery, crematory or other play	ematory 12/			
death certificate be executed death certificate be executed learned by the death of the control	23a. Pant . Empt the disease, or compliance, dramar tailure. List only or Immediata Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in deeth) Last	Due to (or Peren	as a consequence of): AS as a consequence of):	eumonia		Approximata Interval Between Onset and Death	
P.O. hat the d by the detached	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause giv		23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow		
9 8 8 G	Large	Sacral W	lar (Den	VP/(12)	performed?	Were autopsy findings available prior to completion of cause of death?	
Of Vita Physicians this certifical al director	27. Mennar of Deeth Netural 5 Pending Invastigation		ER/Outpatient 3 DOA Other September 28b. Time of Injury M 1	26. Place of Death (Check of D	nnly one) Residence 6 Other (Sp. ribe how injury occurred	1 Yas 2 No	
DIVISION C To the Hospital or Attending P within 24 hours after death. To the Funeral Director. Aftert completely filled in by the funer.	3 Suicida 6 Could not be detarmined	building, etc. (Specify)		28f. Locati City of	ion (Street and Number or F r Town, State)		
To the Hospital within 24 hours To the Funeral completely filled	(Check only 2 Medical Examirone) 29b. Signature and title of coefficient	er: On the basis of examination and mannar stated.	on and/or investigation, in my o	ppinion, death occurred et the ti	29d. Date signed (Mor	ue to the cause(s)	
State Registrar	30. Name and addrass of person who co	mpleted causa of death (Item:	303 Bol	ary Pa Fa	Uston, Md	2104+	

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Lucille M. Coop November 30, 1999 07:00 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Allegany Allegany County Nursing Home Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Deys 1 M 12 F 83 Vrs November 28,1916West Virginia Director 217-10-5048 Usual Residence of Deceden with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21521 State Rt. 36 Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11. Meritel Status Bleck, White, etc. pemil. Pages 1 and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"
any injury or other transmiss. 1 ☐ Yes 2 No It Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify White ğ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Beautician cosmetology 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nancy J. Shaffer Samuel Russell Arthur 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) McDowell Jr./Nephew 1823 Lori Lee Dr., Gallatin, TN 37066 George 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Philos Cemetery 12/02/1999 Westernport MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Boal Funeral Home 10 111 Church St., Westernport, MD 21562 ac 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert tailure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Examiner sician end buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, attending physician ian/Medical the Due to (or as e consequence of) 98 0 Physic signed by the a Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. 2 24b. Were eutopsy tindings eveilable prior to completion of cause ot deeth? Completed 24e. Wes en eutopsy peen hes page 2/5 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate f or Attending Physician: after death.
Director: After this certifica 25. Wes case referred to medical director Be 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) °L 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) in by 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. edical (Check only one) 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d, Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number MENTIL em

Registrar

Vanala A. Ranjithan, MD 517 Oldtown Rd. 31. Dete tiled (Month, Day, Year) DEC

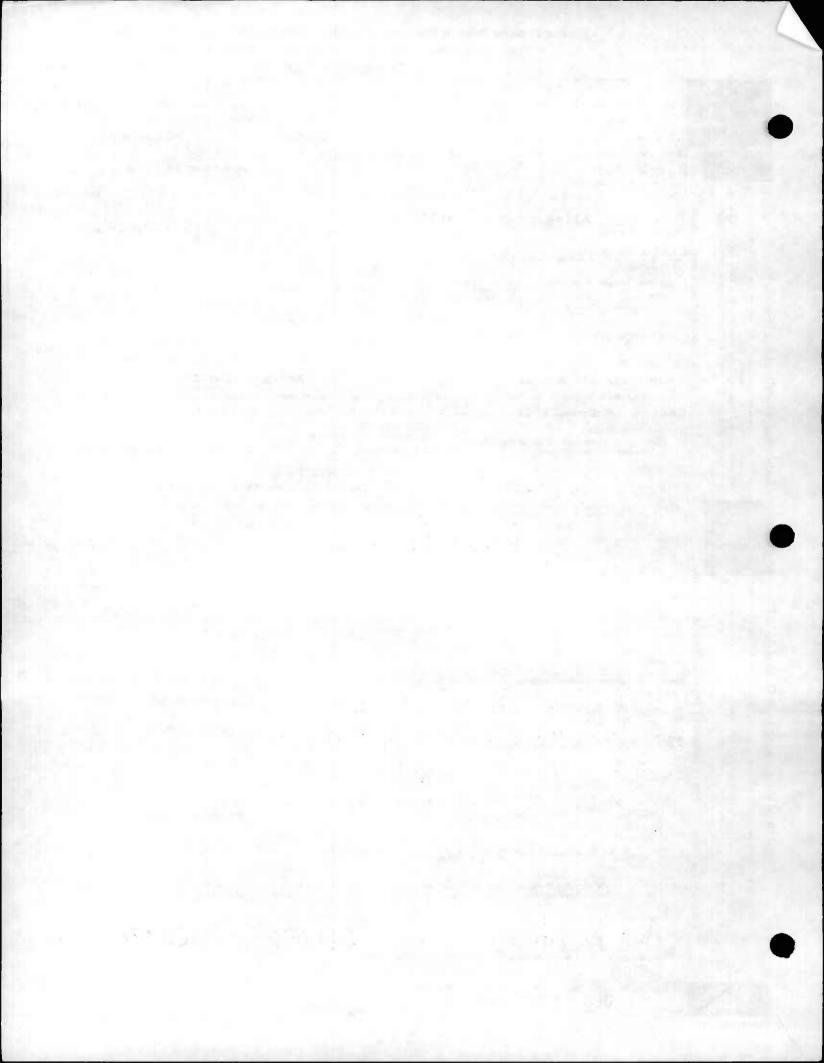
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30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

Cumberland, MD

21502



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Day **Physician** Boyce Tilden (agle DECEMBER 13, 1999 0620 /Medical 4a Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Death 4c. County of Death WICOMICO Examiner SALISBURY Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country). South Carolina 7. Age (In yrs. last birthday) Yrs. 5, Social Security Number 239-03-9989 6. Sex 1 M 2 ☐ F If Under 1 Year Birthplace (State or Foreign Country). **Funeral** Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-1 show with injury or other traumatic event, the Medical Exemples must be notified an once. Virginia 1 Yes 2 No Accomack Funeral Director l'emperance ville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10354 Jerusalem Road 23442 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) (onotruction Iron Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice Robina Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Ruth Cagle Wife 20b. Place of Disposition (Name of camptery, crematory or other place) Temperanceville, Va. 23
Date 20c. Location - City or Town, State 23442 20a. Method of Disposition 20 1 ☐ Burial 2 Cremation 3 ☐ Removel from State Occohannock (rematory 12-15-99 Exmore, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 25. Name and Afteress of Facility Home Salyer tondo (hincoteague, Virginia 23336 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner de ate has been signed by the attending physician end page 2 should be datached for use as the bunal-transit or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, 0 Due to (or as a consequence Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed by 24b. Were autopsy findings available prior to complation of causa of deeth? 24a. Was en autopsy performed? 1 Yes 2E No 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No After this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attanums within 24 hours effer death.

To the Funeral Director: After the Funeral Director of the funeral d 1- Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner as stated.

2 Medical Examination on the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only 29c. License number 29b. Signature and title of dentitie 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVII) WALKER 560 NOVENSIDE DR SALIBBARYMA A206 32. Registrar's Signature 31. Data filed (Month Day, Year). State

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Registrar

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1. Decedent	s Name (First, M	iddle Last)		ri din	Cei	tificate of	Death	2. Dete of D	Reg. No.	3	Time of Death
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4n Facility	eme (If not institu				U.	Larkston	4b. City, Town, o	DECEMBI r Location of Dea			328 PM
	TRAUMA						BALTIMO	RE		N/A	
5. Sociel Se	urity Number	6. Sex		. Age (In yrs.	last birthday)	If Under 1 Yee			irth	9. Birthplace	(Stete or Foreign
215-2	0-4607	1 D M	2⊠F	73	Yrs.	Months Days	Hours Mi	Aug. 1		Marylan	
	ence of Decedent			I.o. o							
10a. Stete	10b. Cou	nty		10c. Ci	ty, Town or Lo	cation					nside City Limits Yes 2 2700
Mary1		ent		C	hestert						LI TOS ZADINO
10e. Street						10f. Zip Code			10g. Citizen of \	Whet Country?	
	Georget					2162			USA		
-	tatus ir Merried 2□ N iwed 4□ Divori	farried	Armed Ford 1 Yes 2 If Yes, Give Yeer or Del			Wes Decedent of f Yes, specify Cu I □ Yes 2 💢 No	Hispanic Origin? (ben, Mexican, Pue Specify:	Specify Yes of Norto Rican, etc.)	Specify	e - American Inck, White, etc. /: Bla	
		dent's Educati			16a. Deced	dent's Usual Occi	pation		16b. Kind of Br	usiness/Industry	
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	of Disposition	• 🗆			Place of Disco	sition (Name of netory or other pl		Date	20c. Location -	City or Town, S	Stete
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21. Signature of Funeral Sequence ticensee 22. Name end Address of Fecility										LLOWILL	ar Arann
Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryla:										1601	
23a. Part1.	nter the disease	, or complicet	ions thet ca	used the deal	th. Do not ent		ring, such es cardi			App	roximete rvel Between
disease or cresulting in	leath)	e	20 14		or as e conseq	uence of):	1317				
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examine XX Yes	? 2□ No	Hosp	oitel: 1 🗆 In	patient 2	ER/Outpatien	t 3 DOA	ther		sidence X6XXXDth	er (Specify) S	CENE
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3 ☐ Suid	-date	ild not be armined	building	f Injury - At h g, etc. (Specif CNS (C	y)	eet, fectory, office		City or To	(Street and Numbown, State)		
29e. Certifie	1 ☐ Certif	ying Physicies Examiner:	on the bas	est of my kno	wledge, deeth	occurred et the	time, date and place opinion, deeth occ	ce, end due to the	e cause(s) end me	enner as stated	cause(s)
one)			end manne	r steted.							
29b. Signatu	e and title of cert	fier	11.				M.E.	3 4	29d. Date signe DECEMBE		
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30. Name an	d address of pers	on who comp	leted cause				D-14.		3 0205		J =
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended #31, NLS, State of Maryland / Department of Health and Mental Hygiene 12/10/99, Allegany County Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death **Physician** December 9, 1999 Albert Caplan 2230 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Sacred Heart Hospital Cumberland Allegany # Under 1 Yaar # Under 24 Hrs. | Months Devs Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** Months Hours Deys 1 MM 2□ F 212-18-2254 Director Sept 26,1911 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Directo Allegany Cumberland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 947 Seton Drive Apt 2 21502 Funeral USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Meritel Status Black, White, etc. 1 Dres 2 No WW II If Yas, Give Yeer or Detes: Never Married 2 Married 21215-0020 1 Yas 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Gas Inspector State 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: if Item 27 is marked other any Injury or other traumetands. Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Hyman Caplan Racheal Leah Kelly 19a. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9212 Kilbourn Ave., Skokie, IL 60076 Stanley Caplan/Nephew 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dec 15 Date 1999 20c. Location - City or Town, Sieta 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete Mikro Kodesh-Bethel Israel Cem. Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funerel Service Licenses 22. Nama and Addrass of Facility
Hafer Chapel of the Hills Mortuary 1302 National Hwy, LaVale, MD 21502 23a. Part1. Enter the discussion or complications that caused had death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure list only one cause on each line. **Physician** Immediata Cause (Final diseasa or condition resulting in death) /Medical neummua' Examiner Due to (or as e consequance of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trensi Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, the Dua to (or as a consequence of): signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Wera autopsy findings aveilable prior to completion of causa of death? 24a. Wes en eutopsy performed? hes Carcinoma 1 Yas 2 1 No 1 ☐ Yes 2 ☐ No certificate ren To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I 25. Wes casa referred to medicat axaminer? Be 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, larm, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year)

ms State

Registrar

3

DR. GEORGE BREZA, 31. Date filed (Month, Day, Year) DEC

29b. Signeture end title of certilier

912 Seton Dr., Cumberland, MD 32. Registrar's Signeture

30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

December 10, 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 1. 0 5 Q 1

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/Medical	Sara Ellen Dutrow 4e Fecility Neme (If not institution, give street end number)					4	b. City, Town, or I		-		9:10 AM		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Ralph E. Davis 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month Physician RALPH EUGENE DAVIS December 05, 1999 11:20 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SPRING GAP Allegany & O Canal off Route 51 Spring Gap # Under 1 Year | # Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | Min. | MA Y 4, 1963 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 MM 2□ F 36 Yrs 220-88-5467 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No CUMBERLAND Director MARYLAND ALLEGANY 10f. Zip Code 10g. Citizan of What Country? 12218 CAVALIER DRIVE 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, atc. a filed within 72 hours after di Hygiene. other then "natural", or Item 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SHOP SAFETY COORDINATOR 11 RUBBERMAID permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked other eny Injury or other treumatic avant, plats. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be MARY V. CLISE LLOYD F. DAVIS 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MARJORIE ANN DAVIS/WIFE 12218 CAVALIER DR., CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State PBurial 2 ☐ Cremation 3 ☐ Removel from State SUNSET MEMORIAL PARK 8,1999 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD 24. Signature of Funeral Service Licenses 22. Nama and Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 23a. Part1. Enter the discusse or complications that caused the collect. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart teilure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examin physician and s the buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of): been signed by the a should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause contificate has t 2 No 1 Vas 2 No Division of Vital Attending Physician: director, Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only ona) XXX Yes 2 No Other: 4 Nursing Homa 5 Rasidence XXXXIII (Specify) (Scene) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi 28b. Tima of For PBc. tnjury at Work? cod Describe how injury occurred for vehicle that Passenger on motor vehicle that left road and submerged in water 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Naturat To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: Afte completaly filled in by the function. 155 (Faut) 1 Yas 2 No 10:50 ATO City or John, State)

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| Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es sheed.

| Check only | XXX | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time data and place, and due to the cause(s) and manner estated. Cana Medical 29a. Certifier iner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) December 06, 1999 O.C.M.E. 10 completed cause of death (from 23a) (Type, Print) 30. Name and a 111 Penn Street, Baltimore, Maryland 21201 anes nes 32 Aegistrar's Signatura State 1999

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State of Maryland / Department of Health and Mental Hygiene 99 1,0583

sician edical	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month Day	3. Time of Death
Calcul	Joanne Gladys Dia	han b	ECEMBER 10, 19	
miner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Loca		
	THE JOHNS HOPKINS HOSPITAL	BALTIMORE	CITY	N/A
ral tor	5. Social Security Number 265-37-9172 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Age (In yrs. last birthday) Months Da	ear If Under 24 Hrs. 8 nys Hours Min.	Date of Birth (Month, Day, Year) OCT 19 1956	9. Birthplace (State or For Country) MICHIGAN
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin
5	MARYLAND ALLEGANY LAVALE			1 ☐ Yes 2 💢
Directo	10e. Street and Number 10f. Zip Cod	de .	10g. Citizen of V	What Country?
	68 LAVALE BLVD. 2150	0.2	U.S.A.	
Funeral		of Hispanic Origin? (Spec Cuban, Mexican, Puerto Ri		e - American Indian,
Ď	1 Never Married 2 Married 1 Yes, Give 1 Yes, Give Year or Dates:			:k, White, etc. :: WHITE
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du	Elementary/Secondary (0-12) College (1-4or 5+)	one during most of working tired)	Mary Control	
8	12+ 2 DEPT STORE C			L CLERK
å	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Surnam	10)
P	RODNEY RICH	GRACE Lal		
			Route Number, City or Town, IBERLAND MARYL	
	20a. Method of Disposition 20b. Place of Disposition (Name of			City or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	place)		
To Be Comp	4 Donation \$\frac{1}{2}\text{Other (Specify)} \text{CUMBERLAND CREMA'} 21. Separature of Funeral Service Unables 22. Name and Ad		1999 CUMBERLA	ND MARYLAND
8	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ertension		5 yea
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Ę.		gwen in Part I.	1 Yes 2 No	ntribute to the cause of de 3 ☐ Probably 4 Ûnk
by P	Ascites		12 100 12 100	, Aon
Completed	Asthma		24a. Was an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death?
E	Obesity		1 Yes 2 □ No	1 Yes 2 No
Be C	25. Was case referred to medical	26. Place of Death (Check only one)	/
70	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Oth	er (Specity)
	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury	njury at 28 Work? 1 □ Yes 2 □ No	d. Describe how injury occurr	red
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ice 28	f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
	29a. Certifier (Check only one)	e time, date and place, an ny opinion, death occurred	d due to the cause(s) and ma l at the time, date and place,	anner as stated. and due to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 99 40584

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With Po B											of Whet Country?		
8 23	a a	1227 Danielle Dr			217					J.S.A.			
filed within 72 hours aftar death with the Maryland Hygiene. har 'natural', or frems 23a or 28e-f show brt, the Medical Exercitet must be notified at	by Funeral	11. Marital Stetus 1 Never Merried 2 M Merried 3 Widowed 4 Divorced	If Vas Give		In U,S. 13. Was Decedant of Hispenic Origing If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 Who Specify:			in? (Specify Puerto Ric	y Yas or No- an, etc.)	Blec	14. Reca - American Indien, Bleck, White, etc. Specify: White		
in 72 hours	Completed	15. Decedent's E	ducation	16a.	Decedent's Usu	el Occupat	tion			16b. Kind of Bu			
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Physician: r this certific rral director,	To B	examinar? 1 ☐ Yas ∠SNo	Hospitel:	f 2 ER/Out	patient 3 D	Other	h			nce 6 □Othe	r (Cnasit	41	
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ding h. Afte fund	tio	Neturel 5 ☐ Pending	(Month, Dey		njury M	28c. Injury (Work?	es 2□N			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
To the Hospital or Attending Physician: Tha i within 24 hours efter deeth. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not b	OB Diseased Injur	At how a di					Location (Co	root on al bloom		I Paula Music	
Or A Olice of in by	듣	4 ☐ Homicide determined	28e. Pleca of Injur building, etc.	y - At nome, ter (Specify)	m, street, tector	у, опісв		281.	City or Town		er or Hura	I Route Number,	
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To the Hospital within 24 hours e To the Funeral I completaly filled	edical	29a. Certifiar Certifying Pl	nysician: To the best of	my knowledga,	daeth occurred	at tha time	, date end	pleca, end	dua to tha ca	use(s) end me	nner es st	ated.	
To the Hospital within 24 hours of the Funeral completaly filled		one)	nfnar: On the basis of e	ed.	o invastigetion	, in my opii	IIIOII, 088(ľ	occurred 6	ot tria timte, de	ete ena piece, e	nio dua to	ule causa(s)	
To the	Σ	29b. Signature and title of certifier	01		29	c. License	number		2	9d. Date signed	(Month,	Dey, Year)	
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	1	20 Name and - Julian	annual state of the state of th		The main for	SCHAP	H	ina					
		30. Neme end eddress of person who	complated cause of de	eth (Item 23e) (Type, Print) C	asper	m o	line,	177	/	,		
Sta		30. Name and address of person who 3 W. 9 31. Date filled (Month, Day, Year)	complated cause of dec	tre	der 1	ck,	MC	line,	1701				

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State of Maryland / Department of Health and Mental Hygiene 99 1,0585

			Certific			Reg. No.		
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Examiner	4a Facility Name (If not institution, g				wn, or Location of Deat			
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Funeral Director	218-16-7264	7. Age (In yrs.	Yrs. Mon		Min. (Month, Di	ту, Yeer) 7 • 1925	Country) MARYL	Stete or Foreign
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death with the Maryland rms 23a or 28a-f show Linual be notified at neral Director	10a. State 10b. County		ty, Town or Location					Side City Limits ☑ Yes 2 □ No
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23a or	29459 GOLTON :	DRIVE		21601		USA		
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or he	1 Never Married XXMarried	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 959—	1 D V	s 2 No Specify:		Specify	WHITE	
ygiene. Nor than "natural; It, the Medical Ext. Completed by	15. Decedent's l	Education	16a. Decedent's t	Isual Occupation work done during mos Tuse retired)	t of working	16b. Kind of Bu	usiness/Industry	
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and Mental Hyg la marked other surmatic event, To Be Co	17. Father's Name (First, Middle, Las ARCHIE S. EVANS	37)		18. Mothe	er's Name (First, Middle		10)	
and Mental I le marked of sumatic eve	19a. Informant's Name/Reletionship	(Type Print)	10h Mailine Add	ross (Street and Mumb	ISABELLA er or Rural Route Numb		State Zin Code	1
it hash and Mental Hygiens. It hash and Mental Hygiens. Other traumatic event, the Monte Traumatic event	GARY W. EVANS /	SON			E, EASTON,			,
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ot: If	NXBurial 2 Cremation 3 4 Donation 5 Other (Spec	Hemoval from State	cometery, crematory RSONS CEME		12-6-99	SALISBU	DV MAD	ZT AND
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Physician	shock, or heart feilure. List onl	rone ceuse on each line.					Inter	val Between et and Death
/Medical	Immediate Cause (Final disease or condition	chani	LUMANA	horasi.	Jenker	40 10	100	10.
Examiner	resulting in death)	a. Due to (or es a consequence		1 reages en	nya	1	MIG
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s certificate has been director, page 2 should be Completed	25. Wes case referred to medical examiner?	Hospital: 1 Inpatient 2	FR/Outpatient 3	Othor	perf	Yes 2 No	complet of death	on of cause?
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G. Sporks

State Registrar 31. Date filed (Month, Day Year) 0 6 1999 32. Registraris Signature

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Registrar

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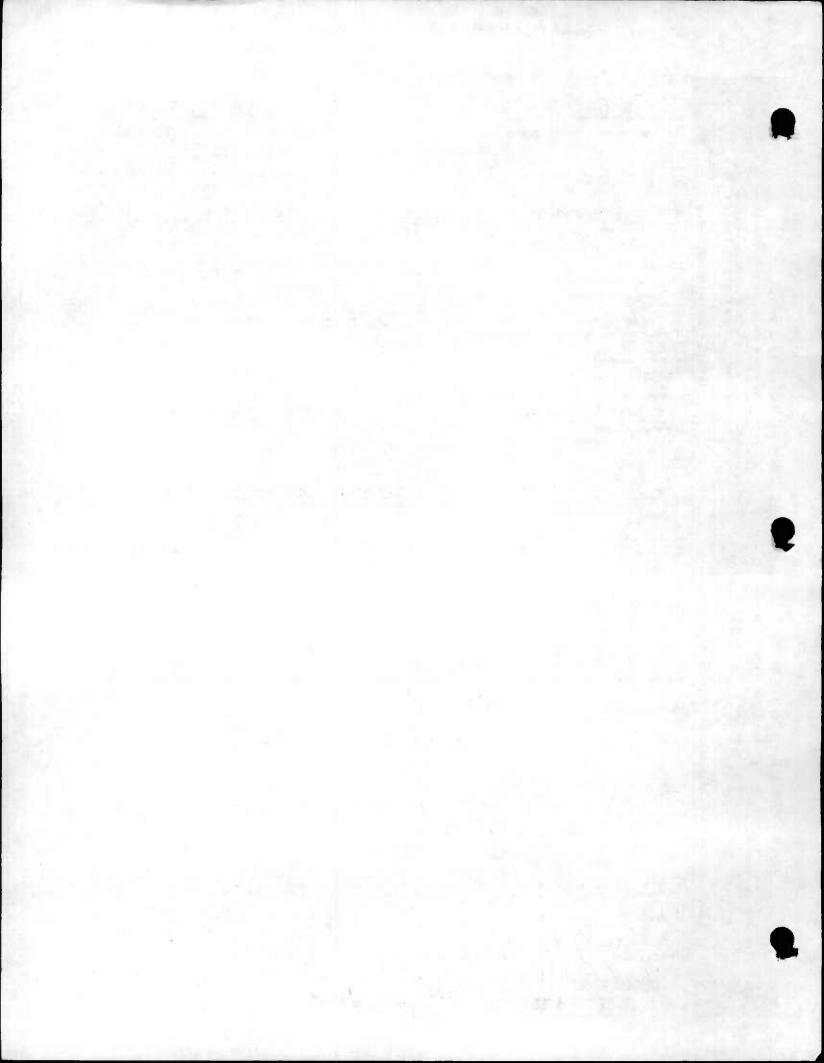
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Inetha Mar fik-48 Facility Name (If not institution, give street and number) 29 12:25 Au NOU /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Collegeview Nursing Home Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 213-40-4094 Yrs. Director 79 Jan 3, 1920 Maryland Usual Residence of Decedent 10s State 10h Counts 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner, must be notified at 1 Yes 2 No Director MD Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4513 Pine Valley Court 21769 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Itam 27 Ia marked other than "natural", or than any injury or other traumatic event, the Medical Experience obses. Black, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) 8 Benjamin Bruner Sarah Christine VanSickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Atwell/daughter 4513 Pine Valley Ct., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sand Spring Cem. Dec. 5, 1999 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Newman Funeral Homes, P.A., PO Box 275 21. Signature of Funeral Service Licenses Rumai 179 Miller St., Grantsville, MD 23a. Part I. Effler the disease, of complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical It haves Examiner Physician/Medical Examiner attending physician and for use as the burlet-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ata has been signed by t page 2 should be detach 1 Yes 2 No 3 Probably 4 Unknown à Records. 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 Tyes 2 No Division of Vitai To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred †-ENatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier (Check only one) 12 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certify 29c. License number 29d. Dale signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) fuleux in M 31. Dale filed (Month, Day,) 32. Registrar's Signature State - 6 1999 DEC Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day Month 6:20 Ar Dwight Otto Folk November 29, 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1**X** M 2□ F 213-12-9730 79 Yrs. Oct 25, 1920 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Somerset Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1981 Springs Road 15558 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1X Yes 2 No If Yes, Give Year or Dates WW 2 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Body Repair Self employed 12 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bruce Folk Olive Kinsinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ferne K. Folk/wife 1981 Springs Rd., Salisbury, PA 15558 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springs Cemetery, Dec. 1; 1999 Springs, PA 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536 TIJ FILLIER ST., Grantsville or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest at List only one cause on each line. Approximate Intervel Between Onset and Death 23a. Part1. Enter the dis Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1□ Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner that the death certificate be executed

Physician

1 /Medical

Examiner

PA

Directo

Funeral

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Completed

2

Funeral

Director

Hem 27 is merked other than "natural", or flems 23s or 28s-f show other treumstic event, the Medical Examples must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Heelth and Mentai Hygiene. Intervent: If them 27 is marked other than "natural", or then my injury or other treumatic event.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records.

Attending Physicien:

the Marylend

with

death

Physician/Medical Examiner p Completed Be Certification: To

the bunel-tren pue physician 82 ettending I use signed by the e been sig page 2 s certificete funeral director, this after death. Director: Aft

27. Manner of Death

 Hospital or Attended
 Funeral Director detely filled in by ti Medicai completely To the Vithin 2

Registrar

3 Suicide 4 Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Yes 2 No

1 Maturel

2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending Investigation 6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

1 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.

| Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s)

2 No

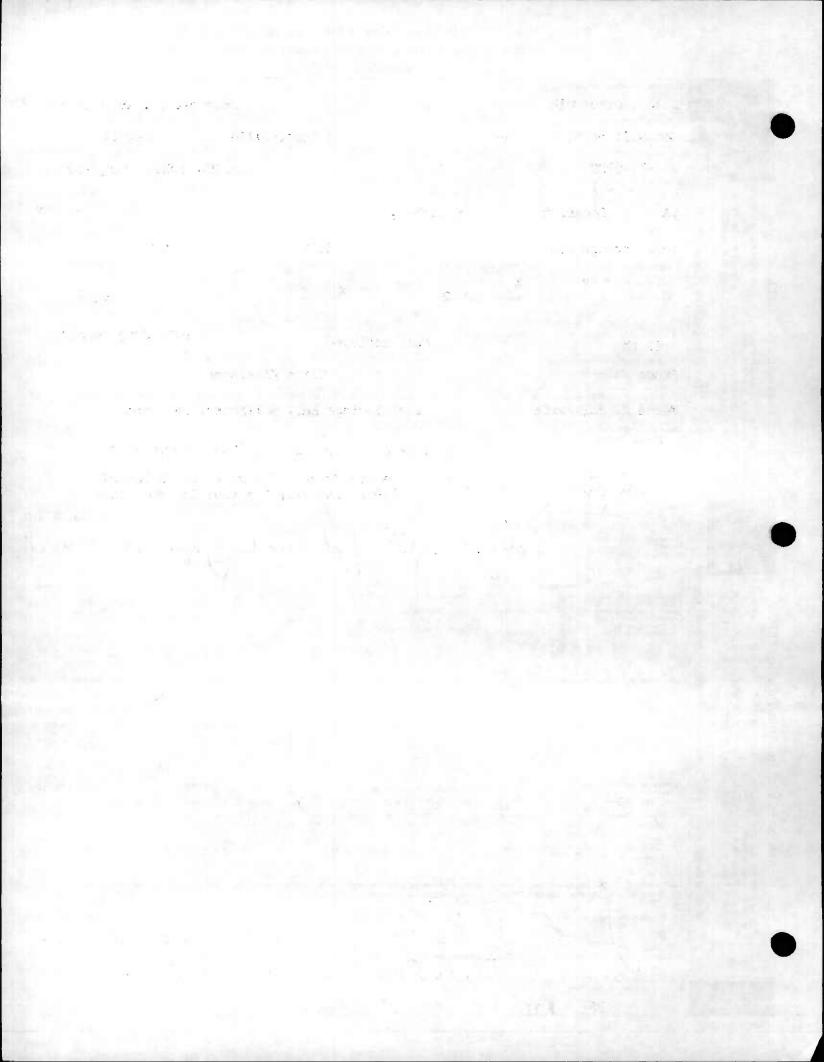
29d. Date signed (Month, Day, Year)

30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) DCI

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Louis Fazenbaker 1999 6, 12:25 pm December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Memorial Hospital 8. Date of Birth Month, Dey, Year, November 19, 1935 Birthplace (State or Foreign Country MD If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 10 M 2□ F Yrs 219-34-5955 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Madical Examiner must be notified at 1 Yes 2 □ No Barton Director MD Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21521 18703 Lower Georges Creek Road deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 12 Yes 2 10 No Air If Yes, Give Year or Dates: Force 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Item eny injury or other treumatic event, the Medical persistence. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Textile Labor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Delphi Elizabeth Miller Delbert Fazenbaker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 E. Main Street, Lonaconing, MD Anthony Fazenbaker Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Hill Cemetery 20c. Location - City or Town, Stata 20a. Method of Disposition December 1 Burial 2 Cremetion 3 Removel from State Lonaconing, MD 08, 1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility James & McKenzie Lonaconing, MD 21539 Eichhorn-McKenzie Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardiomyopathy 3 years Examiner Due to (or as a consequence of): Examiner Congestive Heart Failure 1 week The law requires that the deeth certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? ate has been signed by the page 2 should be detached Division of Vital Records, P.O. 1 Tyes 2 No 3 Probably 4 ⊠Unknown Lewis Fazenbaker P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated.

2 Hedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of d , 1999 7 D36766 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 920 National Highway, LaVale, MD Dr. Vik Poonai

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 9 1999

32. Registrar's Signat

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Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Death 1 Decedent's Nama (First Middle Last) 3. Time of Death **Physician** Mary 4:15 a.m 1999 orence /Medical 4e Fecility Neme (If not institution, give street and numb 4b. City, Town, or Location of Daeth 4c. County of Deeth Examiner Barrick Road inksb If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Carroll If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) 6. Sex **Funeral** Months Deys 10 M 20 F Yrs. 219-42-582 Usuel Residence of Decedent Director the Meryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits Hygiene. kther than "naturs!", or items 23a or 28a-f show ent, the Medical Examinar must be notified at 1 Yes 2 No **Funeral Director** 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mexical Examiner must be an any injury or other traumatic event, the Mexical Examiner must be an and U.S.A.

14. Race - American Indien,
Black, White, etc. 21048 2814 oad Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Battimore County Public School Baker 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Stella Webster Chenowith 2 19e, Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Estell K. Zimmermandaughter Ater 2814 BARRICK

20b. Place of Disposition (Name of cametary, cremetory or other place) FINKSBURG, MD. 21048 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Nama and Address of Fecility Pritts Funeral Home chapel Carroll 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Westminster, MD Approximata Interval Between Onset end Deeth the motienter the mode of dying, such as cardiec or respiratory erres Physician /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner monus) Examiner 20 physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that initieted events resulting in daeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? certificate has b 1 ☐ Yes 2 ☐ No 1 Yas 2 No or Attending Physicisn: director 25. Wes case referred to medical axaminar? Be 26. Plece of Death (Check only ope) Other: 4 Nursing Home 5 Desidence 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 6 ☐Other (Specify) luneral 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the lun 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29e. Cartifier Leaftying Phyalcien: To tha best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner stated. and title of certifier myclish Nogam-30. Neme end eddress of person who completed causa of death (Item 23e) (Type, Print) AGE ANNA CHITTACHEDU

32. Registrer's Signeture

State Registrar 31. Dete filed (Month, Day, Year)

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	Physician /Medical	Donna	Lee	Gulbin					Month DEC.	6, 1999	Year 1833 PM		
	Examiner		(If not institution, give EMERALD AV)			4b. City, Town, or BALTIMORE			of Death		
_	Funeral	5. Social Security			ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Data of B	irth	Birthplace (Stata or Foreign Country)		
	Director	212-50-5 Usuat Residence	0/32	□ M 2 □ F	52 Yrs. Months Days Hours Min.					25, 1947	Maryland		
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	or 28a-f s be notified Director	MD	Baltimo	re	Ba	1timor	7				1 ☐ Yas 2X No		
	Dir.	10e. Street and No					10f. Zip Code				10g. Citizen of What Country?		
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	al. or her frames	1 Never Mar	rried 2 Married	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No	ı,	Yes, specify Cub Yes 2 No	an, Mexican, Puer	to Rican, etc.)	Specify Specify	ck, White, etc.		
	ted attended	/Sn/	15. Decedent's Ed			16a. Decede	ent's Usual Occup	pation	rtina	16b. Kind of Bu	usiness/Industry		
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Maryland 21215-0020 d 2 should be filled within 72 hours eff thend Mente layglene.	Con Training	17 Father's Name	(First, Middle, Last)	5+		Coun	selor	19 Mothade Na	ma /First Middl	State f	unded agency		
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ary	In Mark		Name/Relationship (7			19b. Mailing	Address (Street	t and Number or R			Stata, Zip Code)		
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Baltimore,	T Rem	20a. Mathod of Dis	sposition	Domaval from State		ace of Dispos	ition (Name of atory or other pla	ice)	Data	20c. Location -	City or Town, Stata		
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Ba	Depart Import eny in	21. Signature of F	funeral Service Licen	Buthu	1	100	Name and Addre			r Funera			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line. Approximate Interval Batween											
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	is certificate has a director, page 2	25. Was casa refa examiner?	ALCOHOL: VILLE					26. Place of De	ath (Check only	one)			
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		30. Name and add	Tress of person who d	completed cause of c				Baltimo	re. Mar	vland 21	201		
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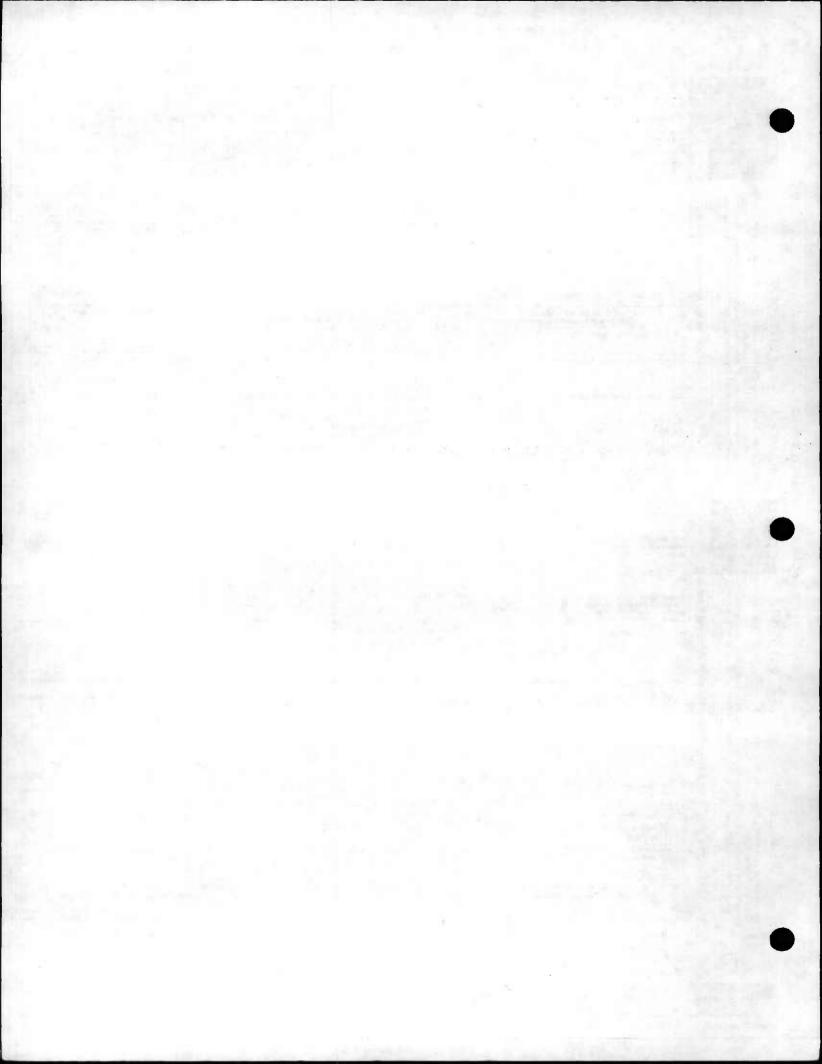
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	Decedent's Neme (First, Middle, Last	st)		ertifica	le oi D	eaur	2. Date			3. Time of Death			
Physician	PAUL CHRISTOPH	ER GANZ					Mont	imber 8	1990				
/Medical Examiner	4e Facility Neme (If not institution, give	e street end number)			4b.	City, Town	, or Location of		County of Dea				
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72 hours after death vinatural; or items 234 dical Examinar must sted by Funeral	11. Meritel Stetus 1 Nevar Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	1 U,S. 1		edent of Hispecify Cuban,		rigin? (Specify Yes or No- n, Puerto Rican, etc.) 14. Race - Amer Black, White						
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and 2 path a r 27 is er tra	Daniel T. Ganz -	Father	751	Palma	Drive	e, Lac	dy Lake,	Florie	da 32	159			
Pages 1 and of He and of H	20a. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ 4 □ Donation SCOther (Specific	Ramovel from Stata	Place of Di cemetery, o	cremetory or	other plece,		Data 12/11/			r Town, Stata Maryland			
Departm Departm Importa any Inju	21. Signature of Funeral Servica Licen			22. Name e	nd Address	of Fecility	Home. P.						
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/Medical Examiner	disease or condition	a ALCOTE	= 12	579/7	DNIT	15				13 DAYS			
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outh outhough	29b. Signature end title of certifiar			25	c. License	number		29d. Date	signed (Mor	nth, Day, Year)			
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	775-250706												
15	30. Name and address of person who de ANDREW NEW	completed cause of deeth (I	tem 23a) (Typ	pe, Print)	1- 11	nin	111 5	- 25	non.	112 21014			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Amend item#7 HCHD 12-10-99 Certificate of Death brh 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JAMES HYNES, CHARLES 12 -4:40 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Fallston General Hospital Fallston 6. Sex 7. Age (In yrs. age 10 M 20 F 66 65 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 9. Birthplece (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 215 304324 Yrs. Director 12-04-1933 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 326 Choice Street 21014 USA 238 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Btack, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1953-57 1 Never Married 2⊠ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 al Hyglene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Gas & Electric Company Substation Operator permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Catherine (nmn) Lancaster James Edward Hynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Eva E. Hynes / Wife 326 Choice Street, Bel Air, Maryland 21014 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Highview Memorial Gardens 12-11-99 Fallston, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Fecility McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014 23a. Pert. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one account on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Ulemia /Medical 19W Examiner rato- Renal Syndrome physicien end a the buriei-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown co apulo jalle à 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1□ Yes 2□ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending PI within 24 hours etter deeth.
To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Registrar

29a. Certifier

29b. Signature and title of certifie

rson who completed cause of death (Item 23a) (Type, Print) . Registrar'a Signature

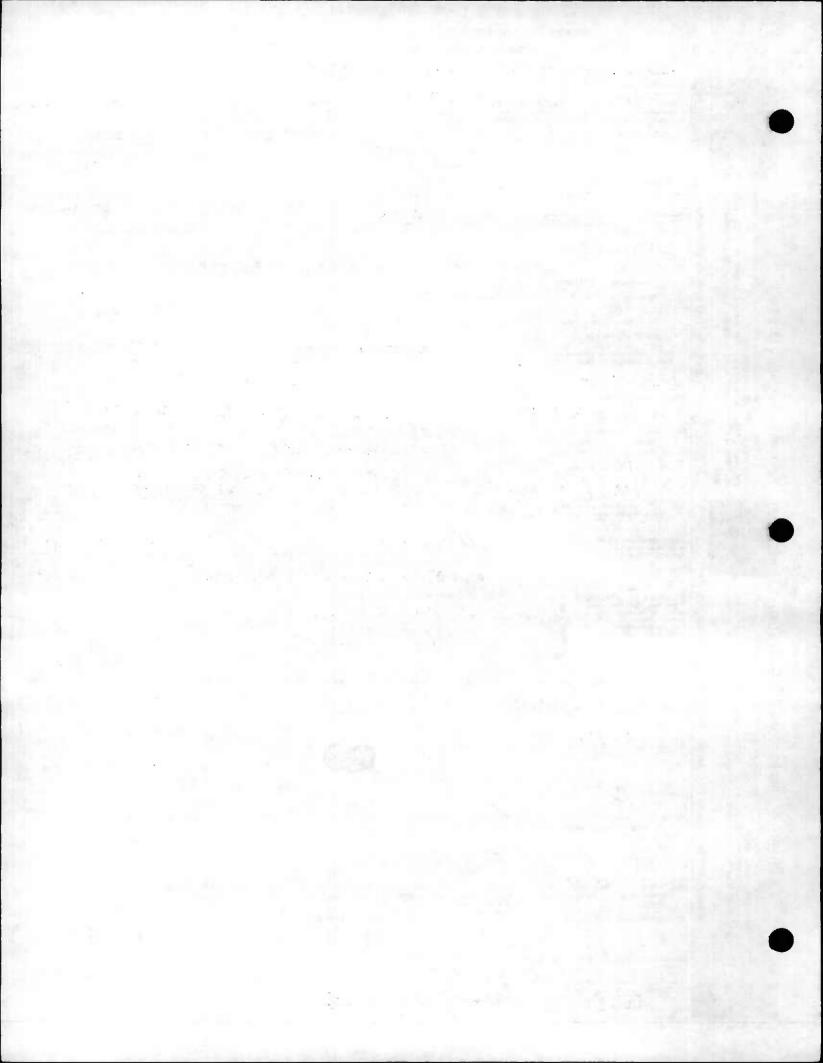
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

132717

29d. Date signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth Physician 0730 De Cember 6, 1999 of Death 4c. County of Death Orsel Tarmon /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 24 Hrs. Hours | Min. 5. Social Sacurity Number 7. Aga (in yrs. last birthday) If Under 1 Yaar 6. Sax 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2□ F Months Days 228 -48 1331 Usual Residence of Dacedant Yrs. Director 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10 Yas 2□ No Pocomoko Worcester Director 10e. Street and Number 10g. Citizen of What Country? 21851 "natural", or items 23a ark Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Giva 14. Race - Amarican Indian. 11. Marital Status 1 Nevar Marriad 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Yeer or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene Important: If frem 27 is marked other than eny injury or other treumatic avant Elamantary/Secondery (0-12) Collega (1-4or 5+) 17. Fathar's Ngma (First, Middle, Last) CONTra 18. Mother's Nama (First, Middla, Maiden Sumama) Be Harmon Nardell -10 DET 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Jown, Stata, Zip Code) Clementine 20a. Mathod of Disposition Rd, 8023 Fleming ville 20b. Place of Disposition (Nama of cematary, crematory or other place) 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Cenetary Gratans 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Bennic Smith Funeral Homo P.O. Box 331 Poco noke Approximate that avail Between Onset and Death 23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical CANCER WITH METASTASIS Examiner Due to (or as a consequence of): Physician/Medical Examiner OLOW physician end Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Lest Dua to (or as e consequance of): Box 68760 Due to (or as a consequance of): Harmon Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown METASTASIS þ 24b. Wara autopsy findings evailable prior to complation of cause of death? Be Completed 24a. Was an autopsy performed? Dorsey 2 X No 1 ☐ Yes 2 ☐ No of Vital 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Injury 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Panding To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical (Check only one)

State Registrar 29b. Signetura and titla of certifiar

31. Data filed (Month, Day, Year)

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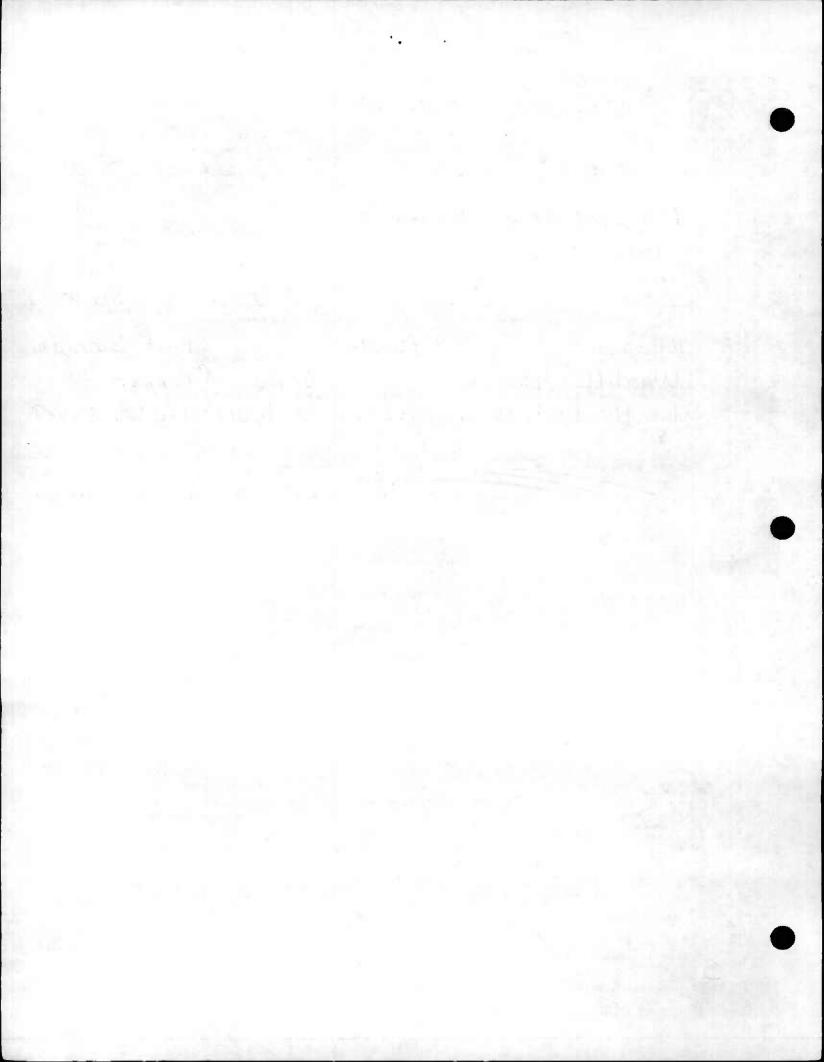
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32. Registrar's Signatura

30. Nama and eddrass of person who complated causa of daath (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 3. Time of Death Day Year **Physician** CHESTER W. HITCHENS DECEMBER 13, 1999 07:18 A.M. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth Month, Dey, Yaar, 04-13-1922 Birthplaca (Stata or Foreign Country)
 DELAWARE 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days Hours 1 X M 2 □ F 77 Yrs. 222-10-8191 **Director** Usuel Rasidence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "naturel", or itema 23a or 28a-f shor traumetic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director DELAWARE SUSSEX FRANKFORD 10e. Street end Number 10g. Citizan of Whet Country? 10f. Zip Code 117 CLAYTON AVENUE 19945 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yaer or Detes: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Introcramt: if them 27 is marked other than "naturel", or then any injury or other traumetic event, the Mental and other traumetic event. Black, White, atc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grede completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HORSE OWNER/TRAINER HARNESS RACING 8 18. Mother's Name (First, Middla, Maidan Sumeme) 17. Father's Name (First, Middle, Last) Be HENRY J. HITCHENS LAURA HUDSON 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rurel Route Number, City or Town, Steta, Zip Code) EDNA HITCHENS/WIFE RD#3 BOX 121, FRANKFORD, DELAWARE. 19945 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) CAREY'S CEMETERY 12-16-99 FRANKFORD, DELAWARE 21. Signature of Funeral Se 22. Name end Address of Fecility MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 comp cations that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, monly one cause on each lina. Approximata Interval Between Onsat and Death 23a, Part1, Eff **Physician** Immediate Cause (Final disaasa or condition rasulting in daath) /Medical 12 hour Examiner Due to (or as e consequence of Examiner the burial-transit requires that the death certificete be executed Sequentially list conditions, if any, laading to immediate ceusa. Entar Undarlying Ceuse (Disaesa or injury that initiated events end Due to (or as a consequence of) attending physician Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequenca of) rasulting in death) Last use as Po Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Honknown à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed Deen hes page 2 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital Attending Physician: 25. Was cese referred to medical axaminar? director, Be 26. Place of Death (Chack only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 10 1 Yas 2 No 1 Minpatient 2 ER/Outpatient 3 DOA the funeral 28b. Tima of Injury 27. Mannar of Death Data of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: de Hospital or Atternation 24 hours efter death. 5 Panding invastigation 1 HNatural 1 ☐ Yes 2 ☐ No 2 Accidant 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicida 6 Could not ba 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Rosert Dorkes 9733 Helloway Dive Burles in D

29c. License number

29d. Date signed (Month, Day, Yaer)

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(Check only one)

29b. Signatura and titla of certifier

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3 Time of Death **Physician** Dec. 1999 0640 MARY FRANCES HAUK /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital at Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** Days 10M 20 F Months Hours 59 216-36-9789 Director OCT.4,1940 MARYLAND Usual Rasidence of Deceden Hauk 10a. State 10b. County 10c. City. Town or Location 10d. fnsida City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ♥ Yes 2 No Director TALBOT EASTON 10a. Street and Number 10f. Zio Code 10g. Citizan of What Country? Baltimore, Maryland 21215-0020 Mary 8298 GANNON CIRCLE 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 12 -0-SECRETARY STATE GOVERNMENT other t permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic event Robes. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be CHARLES PHILLIP SCHMITT MARY BOCKLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT E. HAUK/ HUSBAND 8298 GANNON CIRCLE, EASTON, MD 21601 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WOODLAWN MEMORIAL PARK 12-10-99 EASTON, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Joseph M. Ostrousk. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. **Physician** /Medical Immediate Cause (Final disaase or condition resulting in daath) Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of) use as the P.O. | Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 5 1 ☐ Yee 2 ☐ No 3 ☐ Probebly signed l Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? page 2 2 - No 1 Tyes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death. Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 2 XER/Outpatient 3 DOA edical Certification: To After thi funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No 20 Accidant investigation 6 Could not be To the Hospital or Atterwithin 24 hours after del To the Funeral Director completely filled in by the 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. (Check only one) Medicat Examiner: On the basis of exa and manner stated nation and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to tha cause(s) 29b. Signature and titla of certifier 29d. Date signed/(Month, Day, Year) 12 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) WON KLAR, ST. MICHAELS, MD 21663 M.D., 31. Data filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 8 1999 Registrar Gener

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 99 40597

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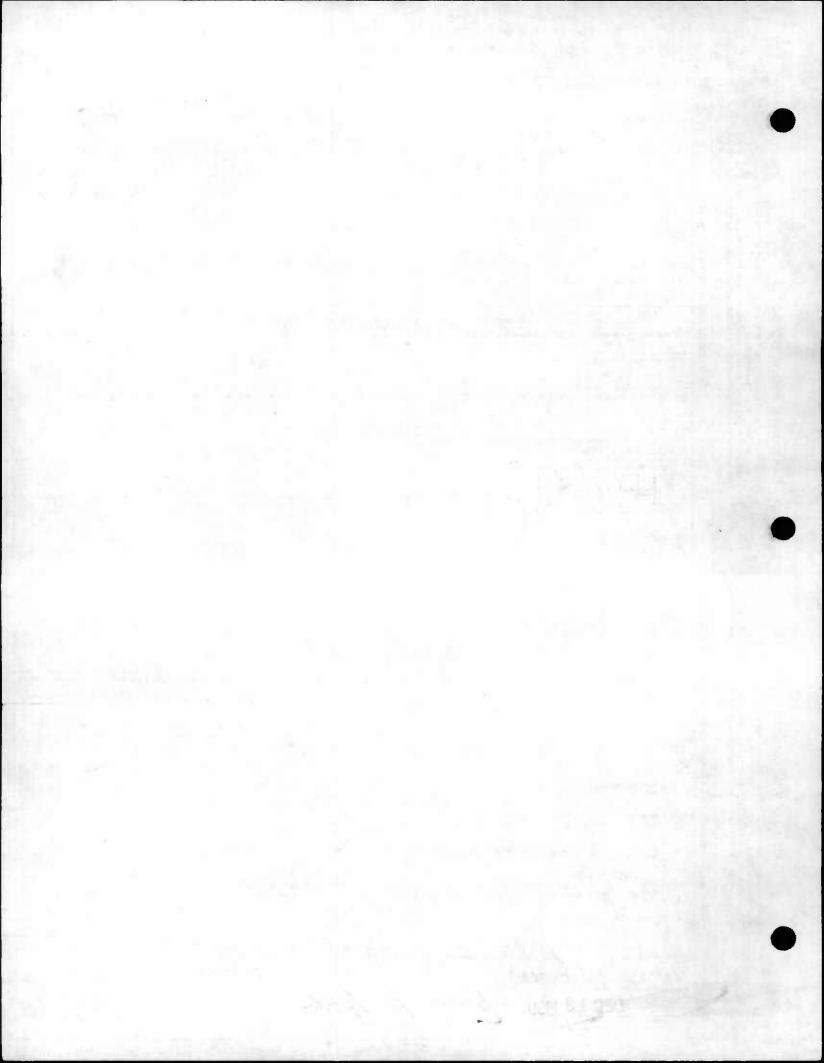
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	State of Maryland / Dep Ce 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. N	3. Time of Deeth						
Physiciar /Medica	HELEN SCHAIDT HELMER		December							
Examine	4a Facility Neme (If not institution, give street end number)			c. County of Death						
Funeral Director	Memorial Hospital 5. Social Security Number 220-48-3650 6. Sex 1□ M 2☒ F 90 Yrs.	Cumber1 Nonths Days Hours Mi	rs. 8. Date of Birth	Allegany 9. Birthplace (State or Foreign Country) 909 MARYLAND						
	Usual Residence of Decedent		100011	JUJ IIIKIIIII						
Aerylan F show		10c. City, Town or Location CUMBERLAND								
the h	10e. Street and Number	10f. Zip Code	10n C	itizen of What Country?						
with or all	635 WASHINGTON STREET									
Seath Fra 2:	11. Menitel Stetus 12. Was Decedent Ever in U.S. 13.	21502 Wes Decedent of Hispanic Origin?		U.S.A. 14. Race - American Indien,						
72 hours after death with the Meryland natural; or items 23s or 28s-f show area Esant of must be notified at the death of the county of the co		Wes Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pus 1 ☐ Yes 2 ☐ No Specify:	erto Rican, etc.)	Bleck, White, etc. Specify: WHITE						
natural,	15. Decedent's Education (Specify only highest grade completed) (Giv.	dent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 16b. I	Kind of Business/Industry						
	Elementery/Secondery (0-12) College (1-4or 5+) OF	DO NOT use retired) FICE MANAGER		HOSPITAL						
e filed el Hygie l other vent, u	12 17. Fether's Neme (First, Middle, Last)		eme (First, Middle, Maide							
should be find Mentel H	HENRY W. SCHAIDT		SANDERS							
should and Men marks umarks	19e. Informant's Neme/Reletionship (Type, Print) 19b. Mail	ing Address (Street and Number or a	Rural Route Number, City	or Town, State, Zip Code)						
and 2 alth 27 la	L. LESLIE HELMER / SON 1440	WEXFORD SOUND DR	., CHARLESTY	ON, SC 29412						
pomit. Peges 1 and 2 should be filed within Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than any injury or other traumatic avent, the Mace.		metory or other place)		Location - City or Town, State JMBERLAND, MD						
permit. Pege Depertment of Important: If any injury or price.	21. Signature of Funeral Service/Cicens 2	UPCHURCH FUNERAL 202 GREENE ST.,		MD 2 1502						
	23a. Part1. Enter the disease, or complications that caused the death. Do not en			Approximete						
Physician /Medical	shock, or heert feilure. List only one cause on each line. Immediate Cause (Final disease or condition Ovarian Cancer			Intervel Between Onset end Deeth MONTHS						
Examiner a	resulting in deeth) Due to (or as a conse	quence of):								
icate be executed physicien end s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):								
ificate be executed g physicien end as the burial-trensit	Cause (Disease or Injury c.	c								
ath certification attending for use as	d									
the death cer y the attendir sched for use	Pert II. Other significant conditions contributing to death but not resulting in the	contribution to death but not resulting in the underlying cause given in Part 1 23h								
thet the death cert ned by the attending a deteched for use		and of the second secon		co use contribute to the cause of death? 25 No 3 Probebly 4 Unknown						
Physician: The lew requires that the death certificate be executed this certificate has been signed by the attending physicien and rial director, page 2 should be deteched for use as the burial-transit: To Be Completed by Physician/Medical Examin			24a. Wes en eut performed?	opsy 24b. Were autopsy findings evailable prior to completion of cause of death?						
The lew ate has bege 2 s			1 ☐ Yes	2 N No 1 □ Yes 2 N No						
elan: entifica ector, p	25. Wes case referred to medical	26. Place of D	eath (Check only one)							
Physician: this certific ral director,	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Home 5 Residence	6 ☐ Other (Specify)						
Attending Pt or deeth. actor: After th by the funera	27. Menner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inj	jury occurred						
25.30	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, ferm, st building, etc. (Specify)	28f. Location (Street e City or Town, Sta	end Number or Rural Route Number, ite)							
To the Hospital within 24 hours a To the Funeral completely filled	29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in end menner stated.									
ro the vithin ro the comple	29b. Signature and title of certifier	29c. License number	29d. D	Pate signed (Month, Day, Year)						
6	Dungmalle V	D 54411	Dec	ember 13.1999						
	30. Name and address of person who completed cause of death (Item 23a) (Type			1.7.						
MAS	Dr. Beverly Calkins, Memorial Hospita	al Medical Bldg.,	Cumberland	, MD 21502						
State Registrar	31. Dete filed (Month, Day, Year), QQQ 32. Degistrar's Signature	Sparker								

DHMH 16 Rev 6/95

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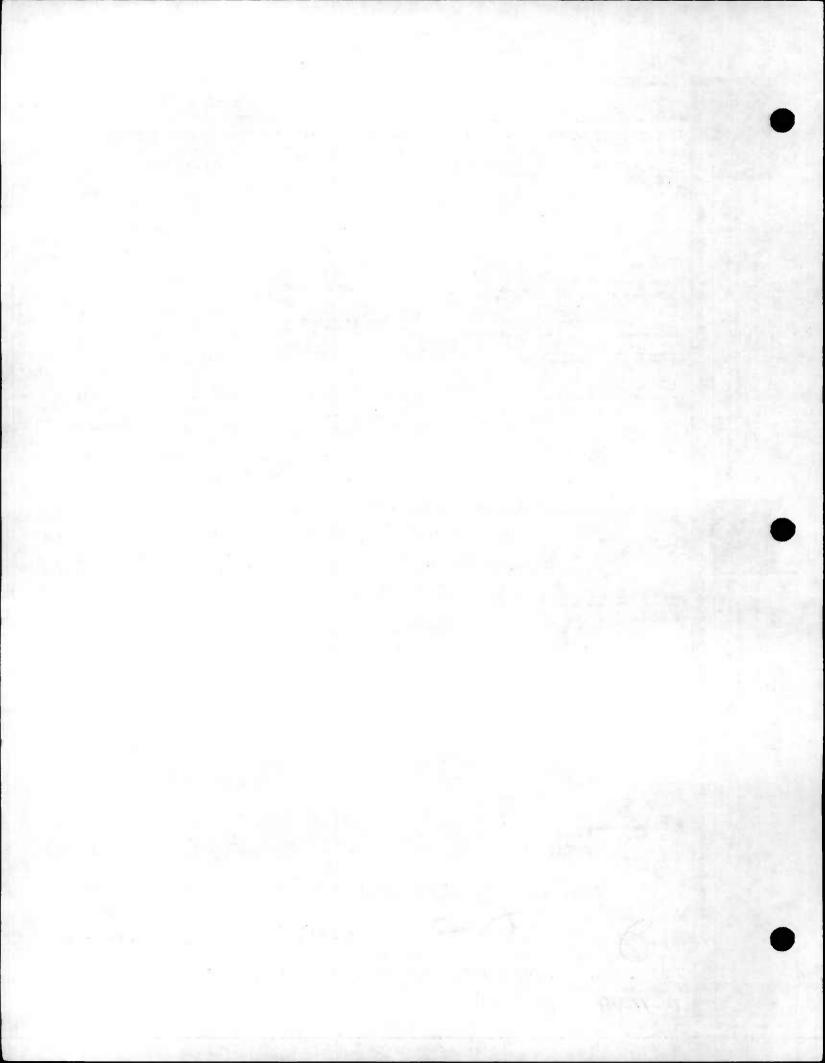
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner es stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. To the I within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 11, 1999 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Jennis 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State DEC 13 1999 Registrar



KATTER, STAITEY

					i yiailu /	Cer	tificate of	Death	F	Reg. No.	7.0	600	
	Physici	an	Decedent's Name (First, Middle, L						2. Dete of Dee Month	Day	Year 3	. Time of Death	
	/Media	_	Stanley Jame						Decembe			0:45 A.M.	
	Examir	ier											
"()			VAMHCS FORT HOWA					FORT HOW		BALTI			
	Funeral Director		358-03-3648	Sex 7. Age 1 M 2 F	(In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	Year)	9. Birthplace IIIIn	e (Stete or Foreign Ois	
	pu a		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				10d	Inside City Limits	
	aho aho	-	MD Harf	har.		ærde						1⊠ Yas 2 No	
	No N	9ctc		J. C.	AL	er de	_			10 00 11			
us after death with the Maryland is or flame 23a or 28e-f show translorer must be notified at	吉	10e. Street and Number				10f. Zip Code			10g. Citizen of V	1 1 1 1 1 1 1			
	rai	628 Rowe Drive	T			210		- # 14	U.S.		la di a a		
	within 72 hours after de ene. than "netural", or frem he Medical Exeminer	by Funeral Director	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1⊠ Yes 2 No								
5	2 ho	Pe	15. Decedent's I	ducation	10	6a. Deced	lent's Usual Occup	pation		16b. Kind of Bu	usiness/Indust	iry	
	Pin 7	Completed	(Specify only highest g	College (1-4or 5-	-)	life. L	OO NOT use retire	during most of work d)	ang				
7		PO.	12	4		cocur	ement An	alyst		U.S. G	overnme	ent	
and	htal Hygied of other	Be	17. Father's Name (First, Middle, Las	1)				18. Mother's Nam	e (First, Middle,	Maiden Sumen	10)		
<u> </u>	Ments Ments price	0	John Kattner					Barba	ra Ette	n			
a	should and Mer america		19a. Informant's Neme/Relationship	(Type, Print)	1	9b. Mailin	g Address (Street	end Number or Rur	ral Route Numbe	r, City or Town,	State, Zip Co	de)	
Σ	end 2 salth e n 27 le		Jacqueline Kat	tner (Spous	e)	628	Rowe Dri	ve, Aberd	leen, Ma	ryland	21001		
a,	一工事者		20a. Method of Disposition		20b. Place	of Dispo	sition (Neme of netory or other ple	ool I	Date	20c. Location -	City or Town,	Steta	
pairimor	permit. Pages Department of Important: If its eny Injury or o once.		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Speed					., Inc. 1	2/12/00	Wort C	hostor	DΛ	
	Departmar Departmar Important Important once.		21. Signature of Funeral Service Lice	**	IX. F		. Name and Addre		2/13/33	West C	nester	PA	
0	Dep ve any		1 111	20		T	arring-C	argo Fune	ral Hom				
	-		somety &	, bang	0			Maryland					
Į			23a. Part1. Enter the diseese, or con shock, or heart feilure. List only	polications that caused to one cause on each line	the death. L 9.	o not ente	er the mode of dy	ng, such as cardiac	or respiratory ar	rest,	Int	proximate ervet Between nset and Death	
	Physician			ייד פיינות מיינות	AT CAL		MAROCIC				1		
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	PERITONE	AL CA	KCINO	MATUSIS				12 1	months	
		ner	Due to (or as a consequence of): ADENOCARCINOMA, COLON b. Due to (or as a consequence of): ADENOCARCINOMA, COLON b. Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
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09/90	ata be hysici	edicai											
	v requires thet the death certific been signed by the ettending p should be detached for use es	Physician/Mec											
	deat e ett	Sich	Part II. Other significant conditions	contributing to death but	t not resulting	a in the ur	ndertving cause giv	ven in Part I.	23b. Did tobacco use contribute to the cause of deat				
5	by th	hys							1 Yee 2 No 3 Probably 4 Unki				
-	the det	y P		I I I I I I I I I I I I I I I I I I I					, ,			.,	
cords,	requires een sign hould be	B							24a. Was	an autopsy		eutopsy findings	
3	sho sho	et							perfo	med?	compl of dea	ble prior to letion of cause ith?	
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=	certil	o Be	25. Wes case referred to medical examiner?	Hospitet:			OII	26. Place of Deal			-		
5	the side	\vdash	1 ☐ Yes 2 ☐ No 27. Manner of Death	145 Inpation		Outpatien b. Time of	I SLI DOA	4 LI Muising no	ome 5 ☐ Resid		11.		
DIVISION	eath. or: After the fune	Certification:	1 ☐ Naturet 5 ☐ Pending investigation		Year)	Injury	M 1	rk? Yes 2 No					
2	s aftar d i Direct od in by	Certifi	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town,								er or Rural R	oute Number,	
	To the Heeptal or Attending Physician: The law within 24 Hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of e and manner state	examination	ige, death and/or inv	occurred at the tirestigation, in my o	me, date end plece, opinion, death occur	end due to the dred et the time, d	ceuse(s) and me date end plece,	enner es state end due to the	ed. e cause(s)	
	withir To th	W	29b. Signature and title of certifier	10,2	wa?	=/_	29c. Licens	se number 359 (ok	~	29d. Date signe	d (Month, De)		
bx	-1	-	30. Name and address of person who	completed cause of de-	ath (Item 23	a) (Type, I		10		Decembe:	r 11, 1	1.999	
0,			JOHN S. LAH, M.D	9600 NOR	TH POI	INT R	OAD, FOR	T HOWARD,	MD 210	52			
	Sta Registr		31. Dete filed (Month, Day, Year) 12-//-990 13	32. Registrar	's Signature	19	Low	Ha!					
			, , , , = 0	000		1 .	100 Par 100	MA					

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth Month 3. Tima of Death Yeer **Physician** Francis Hugh Kidwell December 6, 1999
Pation of Death 4c. County of Deeth 12:05 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 419 Pratt Street Allegany If Under 1 Year 5. Social Sacurity Number Birthplace (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) **Funeral** 1₩M 2□F Months Days Hours Yrs. 232-01-1288 Director 79 Oct. 2, 1920 WV Usual Rasidanca of Decedent Show 10a Stete 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with julyry or other traumatic event, the Medical Examiner must be notified at once. 1 Yas 2 No Director Md Allegany Luke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Pratt Street 21540 United States Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☑ Yas 2 □ No WWI If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Stetus 1 Nevar Married 2 Merried WWII Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Outside Dept. Foreman 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) B Hugh Kidwell Anna Hook 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Kidwell / Wife 419 Pratt Street Luke, MD 21540 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Nation 3 ☐ Removet from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Peter's Cemetery 12/9/99 | Westernport, MD 21. Signatura of Funeral Service Licansaa 22. Nama and Addrass of Facility 111 Church St. agre Book Boal Funeral Home Westernport, MD 21562 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heer feliure. List only one ceuse on each line. Approximeta Intervel Between Onset and Death **Physician** immediata Cause (Finel diseasa or condition resulting In daath) /Medical a Chronic obstructive pulmonary disease Examiner uk yrs Due to (or es e consequence of): Physician/Medical Examiner ng physician and as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or es a consequence of): P.O. Box 68760. Dua to (or as a consequence of) 950 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à No 3 Probably 4 Unknown Carcinoma of the esophagus Records, P 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy page 2 s is certificate I 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital o Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, I 25. Was casa rafarred to medical examinar? 26. Pleca of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Yas 2 No Medicai Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Mennar of Deeth 28c. Injury al Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of Naturat 5 Pending Investigation 1 Yas 2 No 2 Accident an 24 hour.
the Funeral Director of the filled in by the 3 Suicide 6 Could not be detarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide to cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

In the dicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho. To the Fune completely fil 29a. Cartifiar

STIVP State Registrar

29b. Signature and title of certified

31. Deta filed (Month, Day, Year)

30. Name and address of person who complated causa of daath (ttem 23a) (Type, Print)

Snow, M.D. 124 w 3rd St Cumb.

32. Registrar's Signatura

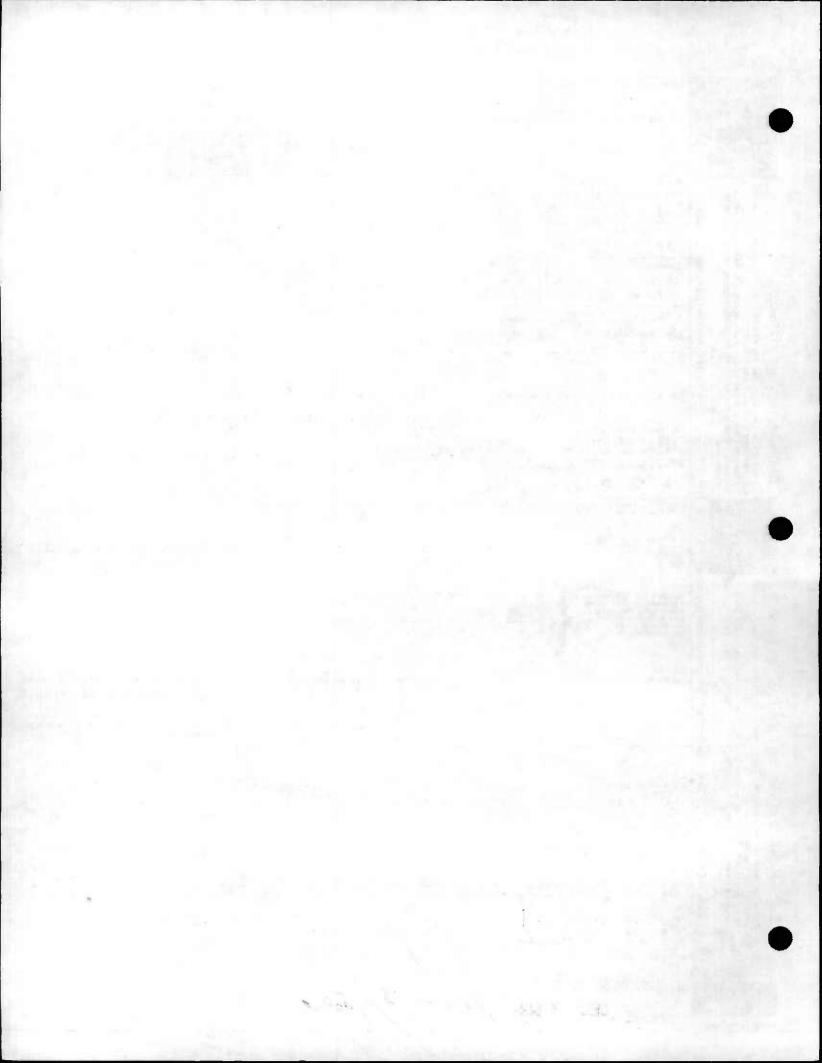
DHMH 16 Rev 6/95

Duty Med Ex

29c. Licensa number

D 09157

29d. Data signed (Month, Day, Year) Dec 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year **Physician** Mary Madeline Kamp 30, November 1999 3:30 am /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Memorial Hospital Cumberland W Under 24 Hrs. | 8, De Allegany If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) March 11,1928 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M XXE Months Days Hours Min. 198-20-1690 71 Yrs. Pennsylvania Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1374 Chestnut Ridge Road 21536 IISA Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 20 Merried Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pemit. Pages 1 and 2 should be filed within 7. Department of Health end Mental Hygiene. Important: if them 27 is marked other than "nx any injury or other traumatic event, the Medicals. Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Klink Ida Foy 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Kamp/Husband 1374 Chestnut Ridge Road, Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State Donetion 5 Other (Specify) Trinity UCC Cem., Dec. 2, 1999 Grantsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 179 Miller St, PO Box 275, Grantsville, MD 21536 Monace 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset and Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical a Subdural Hematoma Examiner 12 days Due to (or as e consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760, thet initiated events resulting in death) Lest Due to (or as a consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 X No 3 Probably 4 Unknown Multiple right hemispheric infarct, parieto occipital Records, Be Completed by 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? and basal ganglia page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 X No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Wes case referred to medical examiner? funerel director, 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Neturel 5 Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide filled In

0 State

Registrar

completely

within 2 To the

Medical

29e. Certifier

(Check only one)

29b. Signeture and title of certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD

sauce -

31. Date filed (Month, Day, Year) 32. Registrer's Signature

DEC 2 1999

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29c. License number

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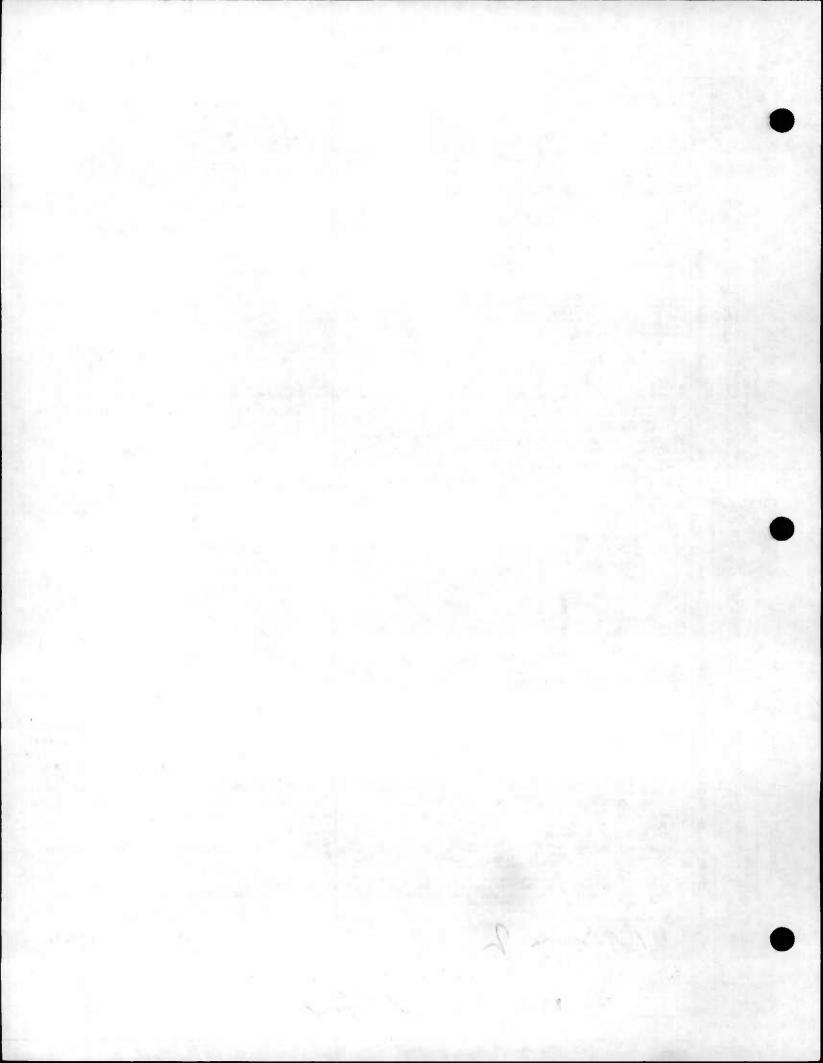
29d. Date signed (Month, Day, Year)

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NOV



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Month 3. Time of Death Yea **Physician** KEMP HUGUST Dec 0837 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton If Under 24 Hrs. Talbot 6. Sex 1 M 2 ☐ F If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV, 3, 192 5. Social Security Number Birthplaca (Stata or Foreign Country)
 D 7. Age (In yrs. last birthday) **Funeral** Deys 215-26-4244 Yrs. Director 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 No Director TAKBOT MD CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 31610 BLADES 21625 USA KOAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Ko R EA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Bleck, White, etc. 1 end 2 should be filed within 72 hours after Heelth and Mental Hygiene. em 27 is marked other than "natural", or Hei 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHTE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CARETAKER CAYETAKER-ESTATE 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be KEMP MOLLY HLFRED WILLIAMSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) BLADES permit. Pages 1 end Department of Heelth Important: If Item 27 I any Injury or other tr. once. 31610 MAIVI KEMP (OrDOVA. MD. 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) APITAL CREMATOR DOVER 21. Signature d Furreral Service Licensee) HOME FEDER ASBUYE. Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical urs Examiner Due to (or as a consequence of): / Physician/Medical Examiner RND The law requires that the deeth certificate be axecuted use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated experts.) eary Box 68760. 435 C 4051 that initiated events resulting in death) Last Due to (or as a consequence of) signed by the eld be detached for P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy tindings evailable prior to completion of causa of death? Be Completed 24a. Was an autopsy performed? this certificate 1 Tas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: funaral director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending invastigation 24 hours after death. 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I ŝ 29b. Signature and title of gariff 29c. License number 29d. Date signed, (Month, Day, Year)

Registrar

State

Ave.

RASTON, MD.

508 TOLEWILD

32. Registrar's Signatura

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

SANCHEZ

DEC 0 8 1999

31. Date filed (Month, Day, Year)

		, NLS, 12				Cer	tificate of	Dealli	2. Dete of De	Reg. No.		3. Time of Death	
/sician				oeth Koh	lor				Month Dec	Day	Yeer 999	1705	
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aminei				y Nursi		ome		Cumber		Alle		NZ.	
eral	5	. Social Security Num				last birthdey)	If Under 1 Year	If Under 24 Hrs.					
tor		149-34-5	5499	□M 2K□F	85	Yrs.	Months Days	Hours Min.		9. Birthplace (State or Foreign Country) HOLLAN			
	-	Jsual Residence of De								10d. Inside City			
9			Ob. County			y, Town or Loc	ation						
Firmeral Director		Maryland		egany	La	Vale		70.0	1 □ Yes 2 ₺				
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Re		7. Father's Name (Fir	rst, Middle, Last)					18. Mother's Nar	ne (First, Middle,				
	0	Conrad S	Sundman	1				WElizah	eth Bo	rgeste	in		
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete,										Code)	
		Elizabeth K. Preston/Daughter 79 Thorpe Ave., Avenel, NJ 07001											
	2	Oa. Method of Dispos			20b. P	lece of Dispos	ition (Neme of	aca)	Date	20c. Location -	City or To	own, State	
		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Dec											
8000	7	4 Donation 5 Other (Specify) Silbaugh Crematory 9,1999 Uniontown, PA 22. Name and Address of Facility											
1	T	Hafer Chapel of the Hills Mortuary											
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DHMH 16 Rsv 6/95

DEC 0 9 1999 James 12 Aprel 19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Daath Day Month Yea Physician Kilmer Gladys December 8, 1999 16:08 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland **Allegany** If Under 1 Year 8. Date of Birth (Month, Day Year) 1917 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 10 M 20 F PA 82 178-10-6719 Yes Director **Usual Residence of Decedent** 10c. City, Town or Location 10d. Inside City Limits than "natural", or itsma 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1429 Willow Court 21502 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or health injury or other traumatic. 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) retired employee Holiday Inn 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Edward P. Newman Bertha (Campbell) 19a. Informant's Name/Relationship (Type, Print)
Delmar N. Kilmer Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29 Willow Court; Cumberland MD 21502 1429 husband 20a. Method of Disposition 20b. Place of Disposition (Nama of cometery, crematory or other place) 20c. Location - City or Town, State 1 Laurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Parl2/11 Cumberland, MD 21. Signature of Funeral-Se 25 Carberri Fruneral Home P.A. Cumberland, Maryland 21502 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical PULMONARY EMBOLISM Examiner Due to (or as a consequence of): Examiner physicien and s the buriel-transit or Attanding Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) for use as ate has been signed by the a pege 2 should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Division of Vitai Records. à 24b. Wera autopsy lindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate 1 Yes 2 No Director: After this certific I in by the funaral director, 25. Was case referred to medical examiner? å 26. Place of Death (Check only ona) examiner?
1 Yes 2 No
27. Mapher of Death Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending 1 Netural 2 Accident death. 1 Yes 2 No 6 ☐ Could not be within 24 hours effected To the Funeral Director completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide edical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. (Check only one) miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 1999 December D25402

Registrar

Pas

State

47 Virginia Avenue

37. Registrar's Signature

21502

Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William D. Lamm

Contract Themillian

DEC 1 0 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

		1 Decedes to 11	o (Fine 14:43)	n atl		Cer	tificate of	Death		Reg. No.		2 Time of Death
Physicia	an	1. Decedent's Nam	e (First, Middle, Li Robert						2. Date of De Month	Day	Year 999	3. Tima of Death 3:30am
/Medic		4a Facility Name (naal .			Ah City Town o	Dec			3:30am
Examin	er)er/			Westmi		eath 4c. County of Death Carroll		
		5. Sociel Security N	K Hill		. Age (In yrs. last	hirthray)	If Under 1 Year					
Funeral Director		215-26-1	Months Days					lace (Stete or Foreign try) MD				
hand land		10a. Sfate	10b. County		10c. City, T	own or Lo	cation				11	0d. inside City Limits
Mary P-f sh	to	MD	Carro	11	We	estm	inster					1 ∑Yes 2 □ No
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Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Physiene. Important: If Nem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other trsumatic event, the Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Married 1 Yes,		12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	☑ No 1 □ Yes 21 1			iban, Mexican, Puerto Rican, etc.)			14. Raca - American Indian, Black, White, etc. Specify: White	
5-C	Completed	(Spec	15. Decedent's E	ducation ade completed)	1	6a. Deced	lent's Usual Occu	pation during most of w	orking	16b. Kind of B	siness/inc	lustry
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tygie d	e Co	17. Father's Name	/First Middle Las	<i>e</i> 1		141	echanic		ame (First, Middle,			10
and did be did b	To Be		Robert						Elizab			
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Baltimo pemit. Peg Department Important: I any Injury o	1	21. Signature of E	7		EVC.		Name and Addr		+-//	<i>y</i> 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Doar	5 , 112
Balt permit. Depart importu		V.	-A-	<u> </u>		P	ritts :	Funeral	Home a			WD 011 F
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Examiner		disease or condition resulting in deeth)	in	· Brow	ranoge	ewic			wwq		i	Sano
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uted d ensit	Examiner	Conventially list on	aditions C	b	Due to (or as	e consec	nence of):				1	
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deat deat of a fo	sici	Pert II. Other signi	cant conditions	contributing to deal	th but not resultin	g in the ur	the underlying cause given in Part I. 23b. Di			Did tobacco use contribute to the cause of death?		
I RECORDS, P.O. BOX 68/60, The law requires that the death certificate be executed are hes been signed by the attending physician end page 2 should be detached for use as the burlet-trensit	Physician/Medical	1/1	o a Calc	a tat	Lle a	1 2 2 and 1 1 Yes				Yes 20 No	3 Prot	pably 4 Unknown
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ath.	atlo	1 □ Maturel 2 □ Accident	5 Pending Investigation	on	,,	,,		Yes 2□No	1			
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Ta set of in the control of the cont	Certification:		1	34,13,118	(
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only		hysician: To the be miner: On the bas								
the H tin 24 the F	ed	one)		and manne		SHOOT III			at the time,			
To To	≥ .	29b. Signature and	title of certifier	0	N. O.	040 AC	29c. Licer	nse number	0.01	29d. Date signe		Dey, Yeer)
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		/00A F	oole Roa	d Westr	minster,	MD 2	21157	Chitr	achedu Na	aganna,M	I.D.	
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Registr	0.4		JEC 10 4	000	manage	14						

ATTEN TENENTS STORY OF THE STOR

- DEC 1 0 1918 - June 15 1/100 -

Amended Item #20b, Per F.D. 12/13/99, Carroll County, cew Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death Month 3. Tima of Death Evelyn Gertrude Morrow **Physician** 10:00 AM 230 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner RALTIMORE AGNES HOSPITAL Baltimore City Wonths Days Hours Min. APril 6, 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Year) 1939 Missouri 1□M 2√2 F 392-36-5750 60 Yrs. Director Usual Residenca of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore MD Baltimore 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1343 Martin Drive USA 230 21229 14. Race - Amaricen Indian, Black, White, atc. 12. Was Decedant Evar in U,S.
Armed Forces?

1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stetus 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister pormit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event. 18. Mothar's Nama (First, Middla, Maidan Surneme) 17. Fathar's Nama (First, Middla, Last) Be Charlie Lovedy Dorothy S. 19e. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Rev. Ray A. Morrow (HUsband) 1343 Martin Drive, Baltimore, MD 21229 20e. Mathod of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata Menory Gardnes 1 N Buriel 2 ☐ Cramation 3 N Ramoval from Stata 12/14/99 Arcadia, Ohio 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signetura of Funaral Sarvice Licensaa 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) Rot Ani uluno Sykesville, MD 21784 (410)-795-1400 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediate Ceuse (Final disaasa or condition resulting in deeth) . Intracranial Hemorrhuge /Medical 28415 Examiner attending physicien and for use es the bunel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiate ceusa. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Lest Dua to (or as a consequance of): Physician/Medical Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown DIABETES δ 24b. Wara autopsy findings availabla prior to Completed 24a. Was en autopsy performed? complation of ceuse of death? NORROW 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 Sanpatiant 2 ER/Outpatient 3 DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 2 Yas 2□ No 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred edical Certification: 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to tha causa(s) end manner es steted.

2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end mennar stetad. 29a. Cartifiar (Check only one) 29c. License number 29b. Signatura and titla of certifian 147484 30. Nema end address of person who complated ceusa of death (Itam 23e) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

E. Shepard

31. Date filed (Mont)

DEC 13 1999

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32. Ragistrar's Signatura

Baltmore, MI)

Wood C. P. C. T. S. T. S

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DEC 13 1999 James 15 Aprents

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ 40608 Certificate of Death Reg. No 1. Decedent's Nema (First, Middla, Last) 2. Data of Daeth 3. Time of Death Month Day Yaar Charles Gibson Mather Jr. 9 1999 4:50pm Dec 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Carroll 2113 Harvest Farm Road Svkesville If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) Days Hours 217-07-8606 1 M 2 F 84 Yrs. Aug 17 1915 Md Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md Carroll Sykesville 1 X Yas 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2113 Harvest Farm Road 21784 USA 12. Was Decedant Evar In U,S. Armad Forcas? 1 X Yas 2 □ No 1944– If Yas, Giva Yaar or Datas: 1946 Was Decadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 1 Never Married 2 ☐ Married 1 ☐ Yas 2 X No Spacify: Specify: white 3 □ Widowed 4 □ Divorcad 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Baltimore City Elemantary/Secondary (0-12) Collaga (1-4or 5+) project manager 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Malden Sumama) Charles Gibson Mather Sr. Lula Groves 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Christine Melville (daughter) 2113 Harvest Farm Rd., Sykesville, Md 21784 20b. Placa of Disposition (Name of cemafary, cramatory or other placa) All County Cremation 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State 12-10-99 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Haight Funeral Home & Chapel 21. Signatura of Funeral Service Licensaa Vaige Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disaesa or condition resulting in death) Lun 2 WKS Due to (or as a consaquanca of): Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in daeth) Last Due to (or es e consequence of): Due to (or es e consaguance of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco usa contribute to the ceuse of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Khowh Nohe 24b. Were eutopsy findings evailabla prior to complation of ceuse 24a. Was an autopsy of death? 1 Yas 2 No 1 TYes 2 No 25. Wes casa rafarrad to medical axaminer? 26. Pleca of Daeth (Check only ona) Othar: 4 Nursing Home 5 Rasidence 6 Othar (Spacify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28e. Deta of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28d. Describa how Injury occurred 28c. Injury at Work? 1 Naturel 5 Panding 1 Yas 2 No investigation 2 Accidant 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 4 - Homicide

Examiner ettanding physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the should be detached After this cartificate has funaral director, page 2 Hospital or Attanding Physician: '24 hours aftar death.
Funeral Director: After this cartifica ately filled in by the funeral director, t To the Hospital or within 24 hours aft To the Funeral Diccomplately filled in Medicai

Physician/Medical b Completed Be Certification: To

Physician

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Director

rai', or items 23a or 28a-f show Examiner must be notified at

I Hygiene. other than "natural", or its rent, the Medical Examin

permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hyglene. Important, if them 27 is merited other than "any injury or other traumetic event, the Med Bobbs.

Physician

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Completed

Be

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

(Check only one) 29b. Signature and titla of cartifier

29a. Cartifian

1 Cartifying Physician: To tha bast of my knowledge, death occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad.

2 Medical Examinar: On the besis of axamination and/or invastigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated. 29c. License numbar

M.P

D15552 byd.

29d. Data signad (Month, Day, Yaar)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) 225 Washington Haights Wastminster, Ind 21157 M.D. aishtz

31. Data filed (Month, Day, Yaar)

DEC 1 3 1999

32. Ragistrar's Signatura

DEC 2 3 1399 Summer S. Specker

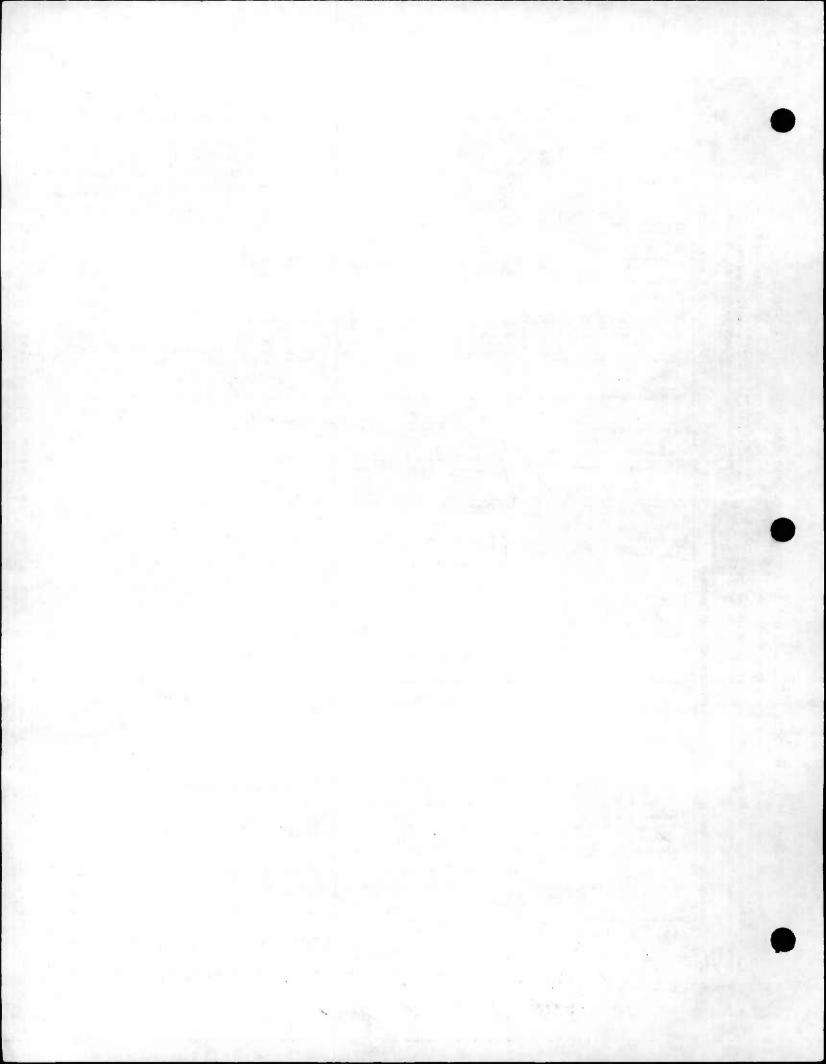
	oll County, cew State	of Maryland		cate of			Reg. No. 9.0	40609		
Physician	1. Decedent's Name (First, Middle, Last) Stella Munha					2. Data of Dec Month	Day	Year 3. Time of Death		
/Medical Examiner	4s Facility Name (If not institution, give street and University of Many land	1 Medical S	System			Location of Death 4c. County of Death				
Funeral Director	5. Social Security Number 6. Sex 1 M 225 Usual Residence of Decedent	7. Age (In yrs. Ia.		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Data of Birl (Month, Da Dec.	Birthplace (Stata or Foreign Country) MO •			
the Maryland 28e-f ahow notified at	10a. State 10b. County Carroll		Town or Location	n				10d, Inside City Limits 1 ☐ Yas 2 🖾 No		
offer deeth with the Maint reme 23e or 28e.f.s closer must be notified closer. Furneral Director	10e. Street and Number 908 Central Ave.		10	of. Zip Code 21	784		10g. Citizen of W			
Dy	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year	Decedent Ever in U,S d Forces? es 2 2 No , Giva or Dates:		Decedent of H s, specify Cuba as 2KMio	lispanic Origin? (S) an, Mexican, Puerti Specify:	pecify Yas or No Pican, atc.)	Specify:	a-American Indian, k, Whita, atc. White		
21215-0020 d within 72 hours eld siene. Then "naturel", or then "naturel", or the Made ell Exemi	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	ge (1-4or 5+)	16a. Decedent's (Giva kind life. DO N Nursin	s Usuel Occup of work done IOT use retired G ASS1:	eation during most of word stant	king	16b. Kind of Bu Spring	siness/Industry field Hospital		
Battimore, Maryland 21215-0 pemit. Pages 1 and 2 should be filled within 72 ho Department of Health and Mentel hygiene. Important: If New 27 is marked other than "nature any injury or other traumatic event, the Medical page. To Be Completed	17. Father's Name (First, Middle, Last) Percy Gray	+1			18. Mother's Nan Annie		Maiden Sumam	a)		
l and 2 sho feelth and h m 27 le ma her traums	19a. Informant's Name/Relationship (Type, Print) Billie P. Donham / daug	hter	P.O.	Box 22	and Number or Ru 03 Ocean	City,	Md. 2184	13		
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permit. Pagas 1 ar Department of Hea Important: if Nem 2 any Injury or other page.	Horas W. Hava	the stranged the death	P.	O.Box	195 Syke	esville,	Md. 217	ome & Chapel 784		
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es that the death cert igned by the attendin be datached for use by Physician/W	Part II. Other significant conditions contributing t	o oeath but not resurt	ting in tha under	ying causa gw	ven in Part I.		Yes 2 No	ntribute to the cause of death? 3 Probably 4 Unknown		
orificate has been signoror, page 2 should be Completed 1						24a. Was perfo	an autopsy med?	24b. Were autopsy tindings available prior to completion of causa of death?		
ystclen: The list certificate he director, pege	25. Was case referred to medical examiner?			low	26. Place of Dec		Yas 2 No	1 ☐ Yes 2 ☐ No		
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the Hospi hin 24 hou the Funer npietaly fill		the best of my knowlee basis of examinetic nannar stated.	ledge, deeth occ on and/or investi	gation, in my o	opinion, death occu	, end due to the rred at the time,	date and place,	and dua to tha cause(s)		
T N N N N N N N N N N N N N N N N N N N	29b. Signature and title of certifier	M.D.		29c. Licens	12507		29d. Date signed	3 (Month, Day, Year)		
	30. Name and address of person who completed of Dance Weiner	22560	ene St		inore, MC	3/20	01			
State Registrar	31. Data filed (Month, Day, Year) DEC 1 0 1999	2. Registrar's Signatu	B.	Spork	N					

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State of Maryland / Department of Health and Mental Hygiene Q Q 1, 0 6 1 0

				Cert	ificate of	Death		Rec	. No.	7 4	0010
	Dhuninina	1. Decedent's Name (First, Middle, L.	nst)	111-5-			2. Dete d	of Death	Dey	Year	3. Time of Death
100	Physician /Medical	Dwight Wil	lliam McKinney				Dece			1999	08:50 PM.
	Examiner	4a Facility Name (If not institution, gi				4b. City, To	wn, or Location of I	Death	4c. Count	y of Death	
		Subu	cban Hospital				thesda		Mon	tgame	ery
	Funeral Director		Sex 1 M 2 F 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Mont)		(ear) 1945		olaca (State or Foreign otry) onsylvania
Jano	Maria Maria	10a. State 10b. County	10c. City, 7	Town or Loc	ation					1	Od. Inside City Limits
the Mar	be notified Director	MD Montgor	mery Be	thesda	10f. Zip Code			100	. Citizen of	What Coun	1⊠ Yes 2□ No
eath with	martha martha	unk	12. Was Decedent Ever in U.S.	140.14	unk	E				USA	
and 21215-0020 be filed within 72 hours after death with the Maryland	'natural', or Nama 23a or 28a-f ahow ad cal Examinar must be notified at leted by Funeral Director	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Styes 2 No If Yes, Give Year or Dates:	11.	Yes, specify Cub.	an, Mexican	gin? (Specify Yes o i, Puerto Rican, etc	or NO-		ck, White,	
12 h	Mylane. Nor than "naturn H, the Medical I	15. Decedent'a E (Specify only highest gr		(Give k	nt's Usual Occup ind of work done	during most	t of working	16	6b. Kind ot B	lusiness/Inc	dustry
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N 2	S F S	12th 17. Father's Name (First, Middle, Las	st	Ass	semblyma		de Mana (Cine Mi		uto M		cture
Maryland 21215-0020	Department of Health and Mental Hygiane. Important: If item 27 is marked other than any injury or other traumatic event, the Mental ance. To Be Compl	James Leo McKinn					r's Nome (First, Mi 1 Irene			me)	
Tar 2 sh	is and	19a. Informant's Name/Relationship		19b. Meiling	Address (Street	and Numbe	er or Rural Route N	umber, (City or Town	, State, Zip	Code)
and and	m 27 her tr	Lillian R. Shaff				ive, (Dakland,				
Pages 1	2 7 2	20a. Method of Disposition 1 Burial 2 Cremation 3 [oe of Disposi netery, cremi	ition (Name of atory or other pla	ce)	Date	20	c. Location	- City or To	wn, State
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Baitimore,	Import any in	21. Signature of Funeral Service USS	List I	22.	Stewart	Funer	al Home	1 1	WI	0155	0
h =		23a. Part1. Enter the disease, or con shock, or heart feilure. List only	plications that caused the death.	Do not enter	the mode of dyir	ng, such as	St., Oak cardiac or respireto	ry arres	t, Ma	_2133	Approximate
Ph	ysician	SHOCK, OF Healt Fellure. LIST Only	A A			1				1	Interval Between Onset and Death
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Ex	aminer	resulting in death)	a. Due to (or a	s a consequ)				
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), executed	physician and as the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or a	s a consequ	ence of):					,	
68760,	sicia e bur	that initiated events	C. Due to (or as	s a conseque	ance of).					-	
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P.O.	igned by the attend be detached for us by Physician/				ony ny oaoso yn		j	1 🗆 Yee			bably 4 Unknown
Ø }	s been s 2 should pleted	Alak III				2		Wes an performe		ava	ere eutopsy findings ailable prior to mptetion of cause deeth2
E .	Page Corr							Yes	2 No	15	Yes 2□ No
Vital	octor.	25. Was case referred to medical				26. Placa	of Death (Check o	nly one)			
of Vita Physicien:	his ce	examiner? 1)X) Yes 2 No	Hospital: 1 ☐ Inpatient 2 🛛 EF	VOutpatient	3 DOA Of	ner: 4 Nu	rsing Home 5 1	Residen	ce 6 🗆 Oth	ner (Specif)	y)
Division of or Attending Phys	re and cear. I Director: After this certificate ha ed in by the funeral director, page. Certification: To Be Com.	27. Manner of Death 1 Natural 5 Pending	Month, Day Year)	8b. Time of tnjury	28c. Injui Woo		HO No	ribe how	Injury occur	1 6	by medocvehille
VISION	Cat the	2 Accident investigation 3 Suicide 6 Could not be	014111	Mac		Yes 201		•			
> ₹	Direction by	4 Homicide determined	28d. Plage of friury - At home building, etc. (Specify)	e, tarm, stree	et, factory, office	- 0-	City o	r Town,	et and rvumi Stete)	per or Hura	I Route Number,
룡	S S	20a Catifics 4Cl Castilla - Pa	1) treet, 1	COCF	VIII	Cr.		ON	TSON	-	County, 1016.
8	Pletely fi	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example	nysician: To the best of my Knowle niner: On the basis of examination	and/or inve	stigation, in my o	me, data an pinion, deal	d place, and due to th occurred et the t	the cau	se(s) and m e end plece,	anner es st and due to	taled. the cause(s)
To the Hospital or	To the Funeral Dir completely filled in Medical Cert	29b. Signature and title of sprtifier	and manner stated.		29c. Licens	se number		290	l. Date signe	ed (Month	Dev. Year)
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	1 1 1 / 1	THE VIEW	ranel "	~~」		.C.M.E			Decer	mber	6, 1999
4	141 NA	30. Name and address of person who	completed cause of death (Item 23	^		Street	, Baltim	ore	Marv	land	21201
	State	31. Date Hillid (Month, Day, Year)	32. Registrar's Signature		,		, was tall	J ,	. au.y.		ne di fia V di
	Registrar	DEC - 8 K	399 manus	B.	don s	61					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Data of Daath Month Day 2:28 pm Dec. 4, 1999 MARY FRANCES LARRIMORE MORRIS 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daeth 4c. County of Daath Talbot Genesis Eldercare - The Pines Easton If Undar 1 Yaar If Undar 24 Hrs Hours Min. Birthplaca (Steta or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sax 8. Data of Birth (Month, Day, Yaar) 10 M 2 F Months Days June 19, 1926 Maryland 215-20-0999 73 Usual Rasidanca of Dacadant 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 XYas 2 □ No St. Michaels Maryland Talbot 10g. Citizen of What Country? 10e Street and Number 10f. Zip Coda 21663 U.S.A. Seymour Ave. 12. Was Decadant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ê No If Yes, Give Year or Datas: 14. Race - Amarican Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Navar Marriad 2 Married White 1 Yas 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elementary/Secondary (0-12) U.S. Post Office Postal Clerk 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Ralph Larrimore Ida Louise Neavitt 19a, informant's Name/Balationship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Son 11607 Englewood Dr. LaPlata, Maryland E. Richard Morris 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Dete 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Dec. 7, 1999 St. Michaels, Maryland 21. Signature of Funaral Sarvice Licansea 22. Nama and Addrass of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 Longre 23a. Part. Entar tha disaase, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Batween Onsat and Daath Immediata Ceusa (Final 10 yr Coronary Artery Disease disaasa or condition rasulting in daath) Dua to (or as a consequanca of) Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consaquanca of): Due to (or as a consequence of): ons contributing to deeth but not resulting in the undarlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown niC Renal Failure 24b. Ware eutopsy findings available prior to 24a. Was an autopsy performed? stic Breast Carcenoma completion of cause of deeth? 1 Yas 2 No estive Heart Failure 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Chack only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. State

Directo

Funeral

2

Completed

Be 2

Funeral

Director

?7 ie merked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Experiment

altimore, Maryland 21215-0020

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death

Examiner Physician/Medicai by Completed Be 9 Certification:

physician and the buriel-transit attending pl ed by the a detached f signed by t peeu 108 page 2 After this funeral is or Attending P s after deeth. I Director: After to d in by the funera filled in by

the death certificate be executed

P.O. Box 68760.

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2 Accident

3 Suicida

29e. Certifier

4 Homicida

25. Was casa rafarrad to medical axaminar? Hospital: 1 Yes 2 No 27. Manner of Death 1 Naturel

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 28b. Time of Injury 5 Pending investigation

28c. Injury at Work? 1 Tes 2 No 28e. Plece of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

Othar: 4 Wursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Dascribe how injury occurred 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

(Check only one) 29b. Signatura and I

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Andrea Allen

1 X Certifying Physician: To the best of my knowledge, daath occurred et tha time, dete end pleca, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred at the time, data and placa, and due to the cause(s) and menner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

as of person who completed cause of death (Itam 23a) (Type, Print) 30. Nama

219 S. Washington St. Easton, Maryland 21601

12 - 6 - 99

State Registrar

Medical

31. Data filed (Month, Day, Year) 32. Registrar's Signatura DEC 0 8 1999 Deneva

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Andrew Committee of the
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** BILLY L. MORTZFELDT 1999 December 11:40 a.m /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland **Allegany** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 20, 1953 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** M 2DF Months Days Hours Yrs. Director 218-46-8960 46 MARYLAND Usuel Residence of Decedent the Merylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits X Yes 2 No Director MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 6 ma 23a 510 BOYD AVE. 21502 USA deeth y Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Sfatus 12. Was Decedenf Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0020 6 If Yes, Give Year or Dates: 1 Yes 2 No Specify: by Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled w Department of Health and Mental Hygien Important: if Item 27 is marked other th any Injury or other treumatic event, the DRCB. LABORER 12 CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be AMOS ROY MORTZFELDT MARY DUTCH LIPSCOMB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HEATHER MORTZFELDT/DAUGHTER 510 BOYD AVE., CUMBERLAND, MD 21502 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State DEC 4 ☐ Donation 5 ☐ Other (Specify) SILBAUGH CREMATORY 9,1999 UNIONTOWN, PA 21 Signature of Funeral Service Licensee 22. Name and Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failing a list only one cause on each line. Approximate intervel Between Onset end Deeth **Physician** immediate Ceuse (Final disease or condition resulting in death) /Medical a. BRONCHIOLITIS OBLITERANS STATUS POST RIGHT LUNG 3 YEARS Examiner Due to (or as a consequence of): TRANSPLANT Physician/Medical Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE UNKNOWN The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): burial-trar Division of Vital Records, P.O. Box 68760, SEVERE CARDIOMYOPATHY UNKNOWN the Due to (or as a consequence of): for use as PREVIOUS TOBACCO ABUSE UNKNOWN Part II. Other significant conditions confributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? od ber 2 No 3 Probably 4 Unknown p ata has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? certificata 1 Yes 1 ☐ Yes 2 ☐ No Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA Inpatient this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending Natural 2 Accident death. 1 Yes 2 No investigation To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 10 D54946 necember 08,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAS Dr. Sprenkle Memorial 31. Date filed (Month, Day, Year) Hospital, Cumberland, MD 21502 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 0 9 1999

Billy Mortzfeldt

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name /First Middle | ast) 2. Date of Death Month **Physician** Miller Omer December 7,1999 0050 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Sep 28, 1924 9. Birthplace (Stete or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 15M 20 F 220-16-6935 75 Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Cumberland Allegany 10e. Street and Number 10g. Citizen of What Country? 8 520 Fayette Street 21502 USA 238 Funeral 12. Was Decedent Ever in U,S. Apped Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or hen any injury or other traumatic event, the Medical Exercises 2008. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Tire Builder Tire Company 17. Father's Name (First, Middla, Last) 18. Mother'a Name (First, Middle, Maiden Surname) Murray L. Miller Pearl (Hannas) 19a. Informant's Name/Relationship (Type, Print)
Carole T. Miller 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)
520 Fayette Street; Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 1 Vaurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gard12/10 LaVale, MD 21. Signature of Funeral Service Licenses 22Scarper111Faraneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart tailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Physician/Medical Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be ext Records, P.O. Box 68760. the Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 書 27. Menner of Death
1 Netural
2 Accident 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Affisi Attending 5 Pending investigation 1 Yes 2 No within 24 hours after dear To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide b Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

In dical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifie (Check only To the 29d. Data signed (Month, Day, Year) 29b. Signature and titla of December 1999 death (item 23a) (Type, Print) 30. Neme end address of Richard Schnitt 743 31. Date tiled (Month, Day, Year) 32. Registrar's Signatura State 0 9 1999 DEC Registrar

DEC 0 9 1999 James & Sports

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Charlotte Louise Nichols December 14,1999 1130 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Dorchester General Hospital Cambridge Dorchester 7. Age (In yrs. lest birthday) 5 3 Yrs. If Under 1 Yeer | If Under 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) Nov. 26, 1946 5. Sociei Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 KF 214-46-2667 Director Maryland Usuel Residence of Decedent permit. Pegas 1 and 2 should be filled within 72 hours after death with the Maryland Department of Haalth and Mental Hyglane. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, in Medical Examiner must be notified at another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 221 Henry Street 21613 Unites States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian Bleck, White, atc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black. Specify: à 3 Nidowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Canning 10th Assembly Line Worker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Stansbury Lee Francis Watson 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 837 Park Lane, Cambridge, MD Amy J. Nichols/Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Durial 2 Cremetion 3 Remove from State 4 Donetion 5 Other (Specify) 12/18 Hurlock, Maryland Petersburg Cemetery 21. Signeture of Furier Service Licenses 22. Name end Address of Fecility Framptom-Hawkins-Eskow Funeral Federal sburg, Ma enter the mode of dying, such as cerdiac or Maryland rdiac or respiretory errest 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not ente shock, or heert failure. List only one cause on each line. Approximete intervei Batween Onset end Deeth **Physician** Immedieta Causa (Finel disease or condition rasulting in death) /Medical Cancer with Brain Examiner Due to (or as a consequence of) Examiner Obacco lew requires that the deeth certificate be executed nding physician and use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted evants resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) for use as signed by the a ld be detached for Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings evelleble prior to completion of cause of daeth? pinous Completed 24e. Wes en autopsy performed? peen page 2 has 1 Yes 2 2000 1 ☐ Yes X No certificata Hospital or Attending Physician: 24 hours after daath. Funeral Director: After this certifica director. 25. Wes cese referred to medical examiner? Be 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 200No 2 ₹P/Outpatient 3 DOA funeral 27. Mannar of Death 28e. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be 28e. Piece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complataly filled in Certifying Physician: To the best of my knowledga, daeth occurred at the time, date and place, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end menner stated. edical 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Dey, Year)

(ambridge

State Registrar 29b. Signature end title of certifier

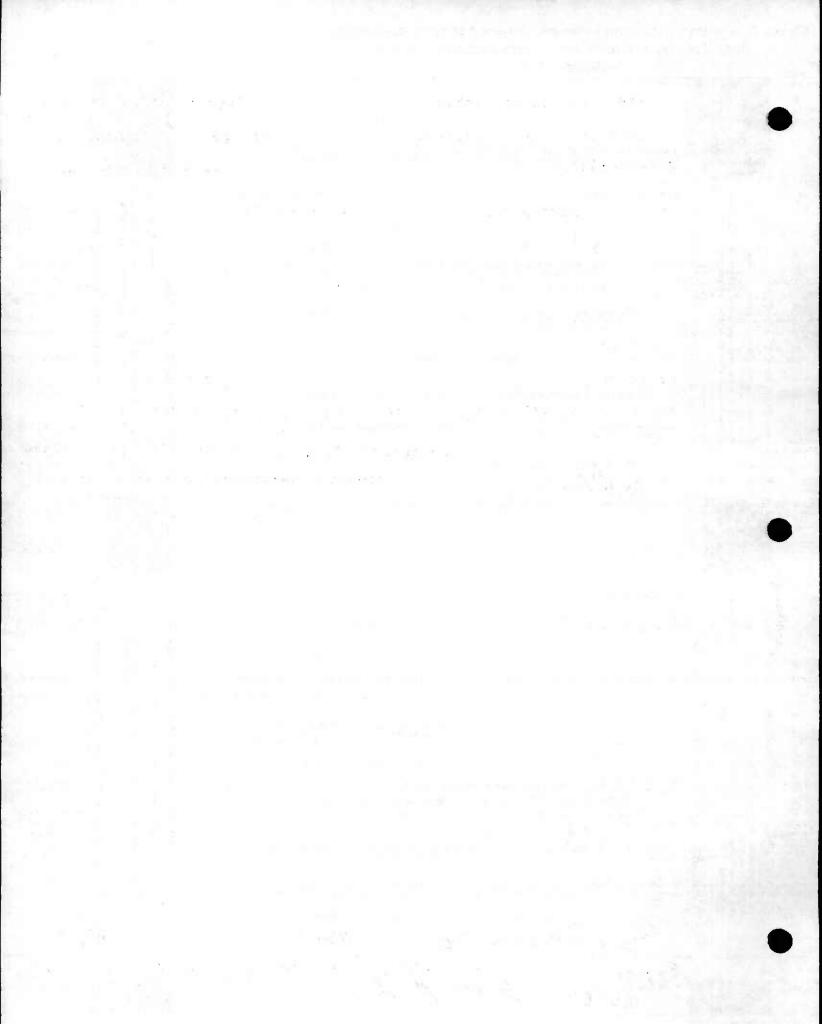
31. Date filed (Month, Day, Year) DEC 1 6 1999

Evgene

30. Name and addrass of person who completed causa of daeth (itam 23a) (Type, Print)

Newmier

132 Registrate Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 40615

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Physicia / /Medic		Grace M. Ow	ing	g s								Month Dec	Day	1999	2:15 pm	
Examine		4a Facility Name (If not institution	n, giva	straat and n	um <i>ber</i>)		***			4b. City, To	own, or Lo	cation of Death		County of Death	1	
4		Long View Nu	rsi	ing H	ome					Man	ches	ter		Carrol	.1	
Funeral		5. Social Security Numbar	6. Sa:	x		yrs. last birti		If Undar	1 Yaar Days	If Undar	24 Hrs. Min.	8. Data of Birt (Month, Day	h Yaar	9. Birth	npiaca (Stata or Foraigr untry)	7
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15-0020 n 72 hours efter death with the Meryland "neturel", or items 23s or 28s-f show edical Examinet must be notified.	3332 Main Street 21102 11. Maritai Status 12. Was Decedant Evar in U.S. Armed Forcas? 1 Navar Marriad 2 Marriad 1 Navar Marriad 2 Marriad 1 Navar Marriad 2 Marriad 2 Marriad 5 No								'-1-0 /C-			USA	e - Amaricen Indian,			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40616 Certificate of Death Amended Item # 23c, 23b, per Phy, 2/28/00, G780, gap 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 3130 PM Ronald December /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner VA Medical Center CITY Ball more Baltimore If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys Hours 1X) M 2□ F 220-42-9372 Yrs. **Director** 54 2/8/1945 NEW JERSEY Usuel Residence of Decedent the Maryland 10a. Sfete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other trsumatic event, it a Medical Examinar must be notified at 1 Yes 2 No WESTMINSTER MD. CARROLL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 HERSH AVE. 21157 USA. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 2 should be filed within 72 hours after and Mental Hygiana. is merked other than "natural; or ite 1© Yes 2□ No If Yes, Give Yaar or Dates: VIETNAM 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) PAPER CARRIER NEWSPAPER 12 17. Fethar's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Be NORA LEE DURHAM GILBERT T. PERRON 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21158 permit. Pagas 1 and 2 sh Department of Haalth and Important: If item 27 is m eny injury or other treun 1250 S. PLEASANT VALLEY RD., WESTMINSTER, MD. LINDA K. LANGDON -SISTER 20b. Ptece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) PIPE CREEK CEMETERY 12/13/99 NEW WINDSOR, MD. 22. Nama and Addrass of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part I. Entar the disease, or complications that caused the death. Do not enter the mode of dylng, such es cardiac or raspiratory errest, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Ischemic Heart Disease Examiner Due to (or as a consequence of): Examiner Renal Failure sician and burial-transit certificata be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or tnjury Due to (or es a consequence of): Box 68760. inding physician usa as tha buria DIABETES Physician/Medical that initieted events resulting in death) Lest Due to (or as e consequence of) signed by the attending d be deteched for use as P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yee 20 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? Completed 24e. Was en eutopsy peau 1 Yes 28 No 1 Yes 2 No this cartificata Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No 70 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Aftar 1 Natural 5 Pending daath. 1 Yes 2 No investigation 2 Accident or Attend after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - Af home, ferm, streef, fectory, office building, etc. (Specify) 4 | Homicide Hospital 24 hours a • Funeral Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune complately file Medical 29a. Certifier

State Registrar

Brown

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signeture end title of certifier

10 N. Greene greet, Buthmore MO 21209 BVAMC 32. Registrer's Signeture

29c. Licanse number

29d. Date signed (Month, Dey, Yeer)

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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month PEACH BRUCE 0021 HV DECEMBER 6 1989 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) RANDALLSTOWN BALTIMORE NORTHWEST HOUSTAL If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1⋤M 2□ F Months Yrs. 43 Feb. 26, 1956 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll Sykesville 10f. Zip Coda 10g. Citizen of What Country? 2135 Stillwater Ct. 21784 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, Whita, atc. 1 ☐ Yes 2 ☒ No It Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) Automotive Co. Auto Mechanic 18. Mother's Name (First, Middla, Maidan Sumame) 17. Fether's Neme (First, Middle, Last) Joan Neumyer Jerome Thomas Peach, Jr. 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 3370 Florence Road Joan L. Pardoe Woodbine, MD 21797 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Lake View Mem. Park 12/9/99 4 ☐ Donetion 5 ☐ Other (Specify) Sykesville, MD 22. Name end Address of Fecility 21. Sign from of Funerel Service Licansee Burrier-Queen Funeral Directors, P.A. -00ry 1212 W. Old Liberty Road Sykesville, MD 21784 Inter the disease, or complications that aus dith death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death 7 DAYS Due to (or es e consequença ot): Due to (or es a consequence of): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown DRUG ABUSE 24b. Were eutopsy tindings eveilabla prior to completion of cause of daeth? 24e. Wes en eutopsy performed 1 ☐ Yes 2 No 1 ☐ Yes a No

Physician /Medical **Examiner**

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Hospital or Attanding Physician: '24 hours efter death. Funeral Director: After this certifice

To the Hospital or Atta within 24 hours efter der To the Funeral Director completely filled in by the

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Examiner

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permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f ahow any injury or other traumatic event, the Medical Examinet must be notined all once.

altimore, Maryland 21215-0020

5. Social Security Number

Maryland

10e. Street end Number

214-64-9863

Usuel Residence of Decedent

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disaesa or Injury that initieted evants resulting in deeth) Lest

Immed of Ceusa (Final death or condition resulting in death)

20a. Method of Disposition

RHABDOMYOLYSIS.

25. Wes case reterred to medical 1 Yas 2 No 27. Mangar of Deeth

Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1/2 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28c. tnjury at Work? 28b. Time of 28d. Dascribe how Injury occurred

Neturel 2 Accident 3 Sulcide 4 ☐ Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Streat and Number or Rurel Route Number, City or Town, Stete)

29c. Licanse number

(Check only one)

1) Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the causa(s) and mannar es stated.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, daeth occurred et the time, dete end placa, end due to the causa(s) end mannar stated.

26. Place of Daath (Check only one)

29b. Signeture end title of certifiar

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29d. Data signed (Month, Dey, Year)

30. Name end eddress of person who complated cause of deeth (Item 23e) (Type, Print)

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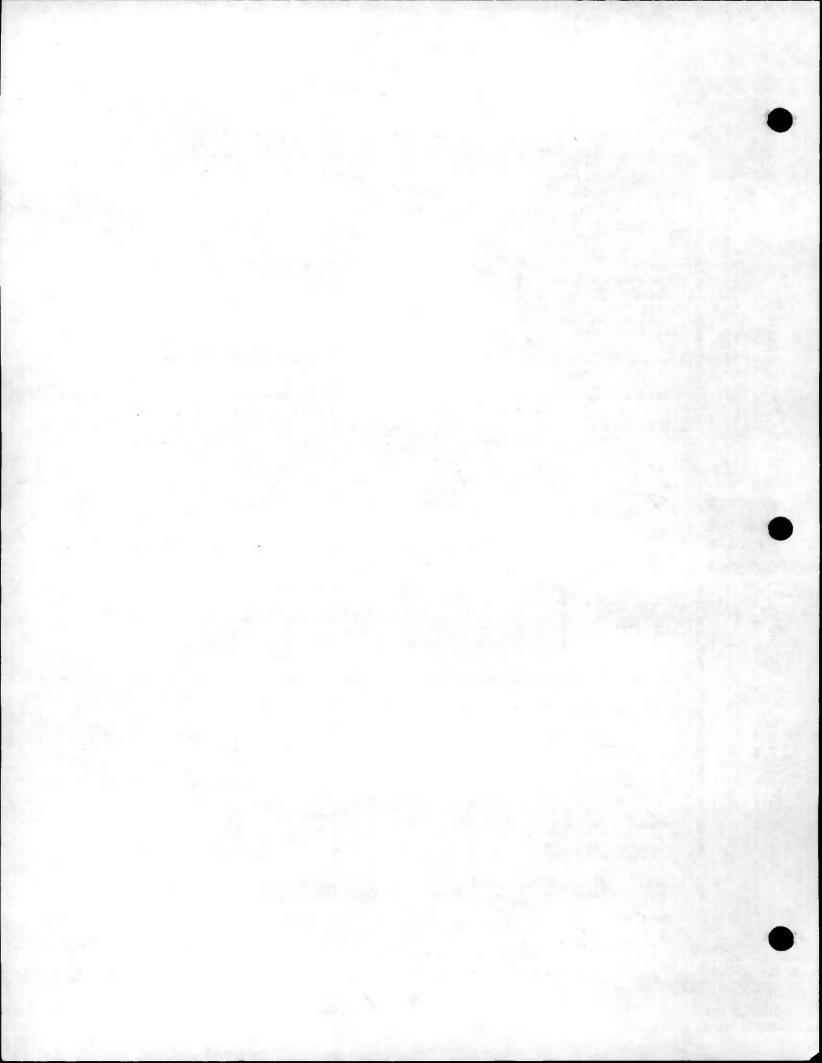
Bosto. NO 21133 5401 Old Court Rd

State Registrar 31. Deta tilad (Month, Day, Year)
DEC 0 8 1999 32. Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Reg. No. 2. Date of Death Month Pag. No.

		Decedent's Name	e (First, Middle, La	ist)		Cel	uncal		Death	2. Date of I			3. Time	of Death
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Funeral	5.	Social Security N	umber 6.	Sex 7. A 1 □ M 2/3√F	ge (In yrs. la	st birthday)	If Unde Months	r 1 Year	If Under 24 H	rs. 8. Date of I	Sirth Day, Year)	9. B	irthplace (State Country)	or Foreign
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death Day Month **Physician** ETHEL A. PROCTOR December 13 1999 7:25 PM /Medical 4a Facility Neme (If not institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHARLES Genesis Elder Care La Plata If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months Hours 1 M 25 F Yrs Director 95 Dec 20 1904 Virginia 119-01-3805 Usuel Residence of Dece death with the Maryland permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiona.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any lujury or other traumatic event, the Mexical Exercines must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2□No Directo Maryland Charles La Plata 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20646 USA One Magnolia Drive 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify þ Specify: Black 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Be P Walter Allen Mary Allen 19a. Informant's Name/Relationship (Typa, Print) 19b. Meiling Address (Straat and Number or Rural Routa Numbar, City or Town, Steta, Zip Coda) 1098 Dorset Drive Waldorf, MD 20602 Robert Leigh (son) 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens 12-18-99 Waldorf, MD 21. Signal 22. Name and Address of Facility Eberwein Funeral Services

4433 White Pls La White Pls., MD 20695
Approximate Interval Between Onset and Death M00173 Eberwein Funeral Services e, or complications that caused the death. Do not er List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine physician end s tha burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest -V ARON LYAN Box 68760. FREBRAL Physician/Medical attanding p HURNID DESCHIE signed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably Unknown Division of Vital Records, þ been si Completed 24a. Was an eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? nis cartificate hes b 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No Attanding Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Chack only ona) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Spacify) 2 this funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation e Hospital or Attandir 24 hours after death. Funeral Director: A plately filled in by the fu death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Numbar, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune complately fi (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yaar) nd address of person who 30 completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

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State Registrar

LONG 31. Dete filed (Month, Day, Yeer)

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Please Type or Print in Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Dey Month Yaai **Physician** RUTH PATTON DECEMBER 8,1999 0845 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 106 11TH STREET OCEAN CITY WORCESTER If Under 1 Year 8. Data of Birth (Month, Day, Yaar)
3-23-17 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 6. Sax **Funeral** 10 M 20 F Yrs. Director 176-07-2821 Usual Rasidenca of Decedan PA. death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane.
Important: if item 27 is merked other then "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet ment to notified any once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director OCEAN CITY WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21842 STREET USA 106 11**T**H Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 D No If Yas, Giva Yaer or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-lt Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Navar Married 2 ☐ Married 1 Yes 2 No Specify À Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 OWN HOME HOMEMAKER 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surneme) Be 2 HENRY MOHR EMMA CURRAN 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) 106 11TH STREET 21842 OCEAN CITY, MD., JANE HALL DAUGHTER 20e. Mathod ot Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Othar (Spacify) 12 - 11LAWN CEMETERY BALTIMORE, MD. to of Fundral Service Licenses 22. Nama and Addrass of Facility ULLRICH FUNERAL HOME BERLIN, plications thet caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory errast, one cause on each line. 23a. Part I. Eprer the diseasa, or com-or heert feilura. List only Approximata Interval Batwaan Onset end Deeth **Physician** Immediata Ceusa (Final disaase or condition rasulting In daath) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed attending physician and for use as the bunal-trans Sequantially list conditions, if any, leeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last Due to (or es a consequance ot): Dua to (or as a consaguance of) ed by the a Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 50No 3 Probably 4 ☐ Unknown MTH signed t by 24b. Ware eutopsy findings evallable prior to Completed 24a. Was an autopsy peed complation of cause of deeth? page 2 s certificate has 1 Yas 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics diractor, Be 25. Was case referred to medicel exeminar? 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 MRasidance 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA funeral Certification: 27. Mannar ot Deeth Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred tnjury et Work? 1, Neturel 5 Panding investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accidant 28t. Location (Straat and Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 6 Could not be 28a. Place of tnjury - At home, farm, straet, tactory, office building, atc. (Specify) 4 Homicide

Records, P.O. Box 68760. Division of Vital

Baltimore, Maryland 21215-0020

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Registrar

State

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29a. Certifiar (Check only one)

29b. Signatura and title of certitian

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at tha tima, data end plece, end dua to the causa(s) and manner as steted.

2 Medicat Examiner: On tha basis of axamination end/or investigation, in my opinion, death occurred at the time, date end plece, end dua to tha ceusa(s) and manner statad. 29c. Licansa number

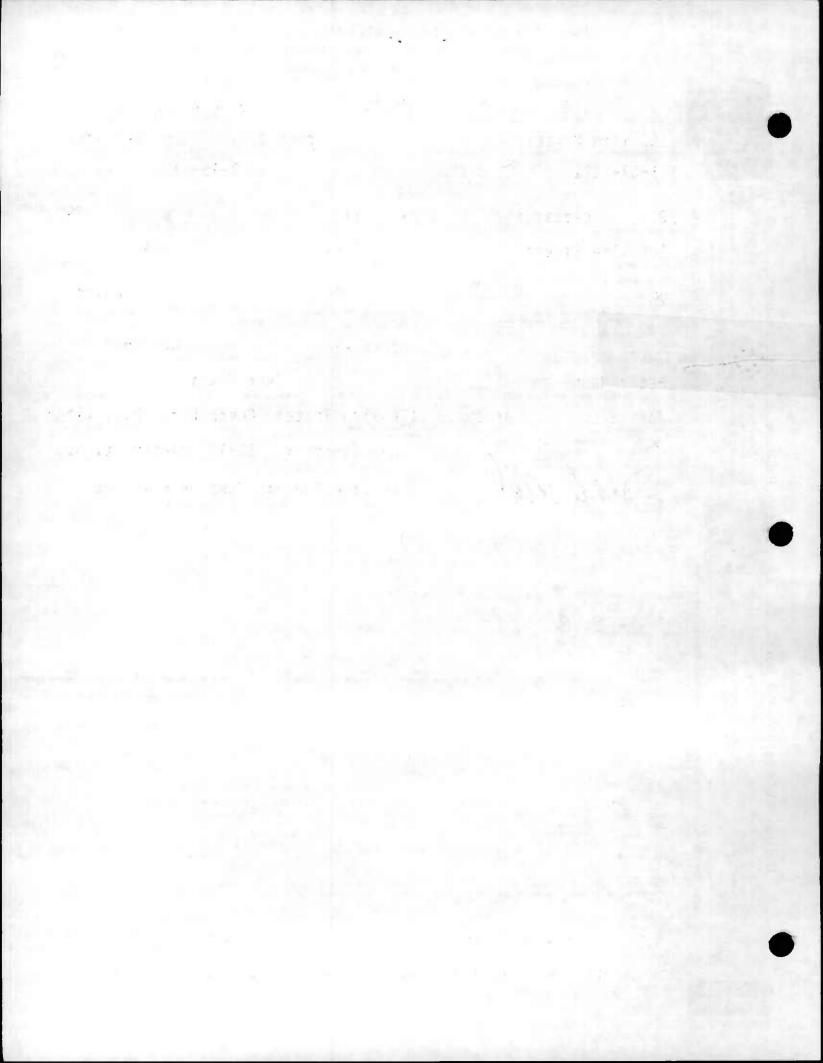
29d. Data signed (Month, Day, Year)

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30. Nama and addrass of person who completed causa of daeth (Itam 23a) (Type, Print)

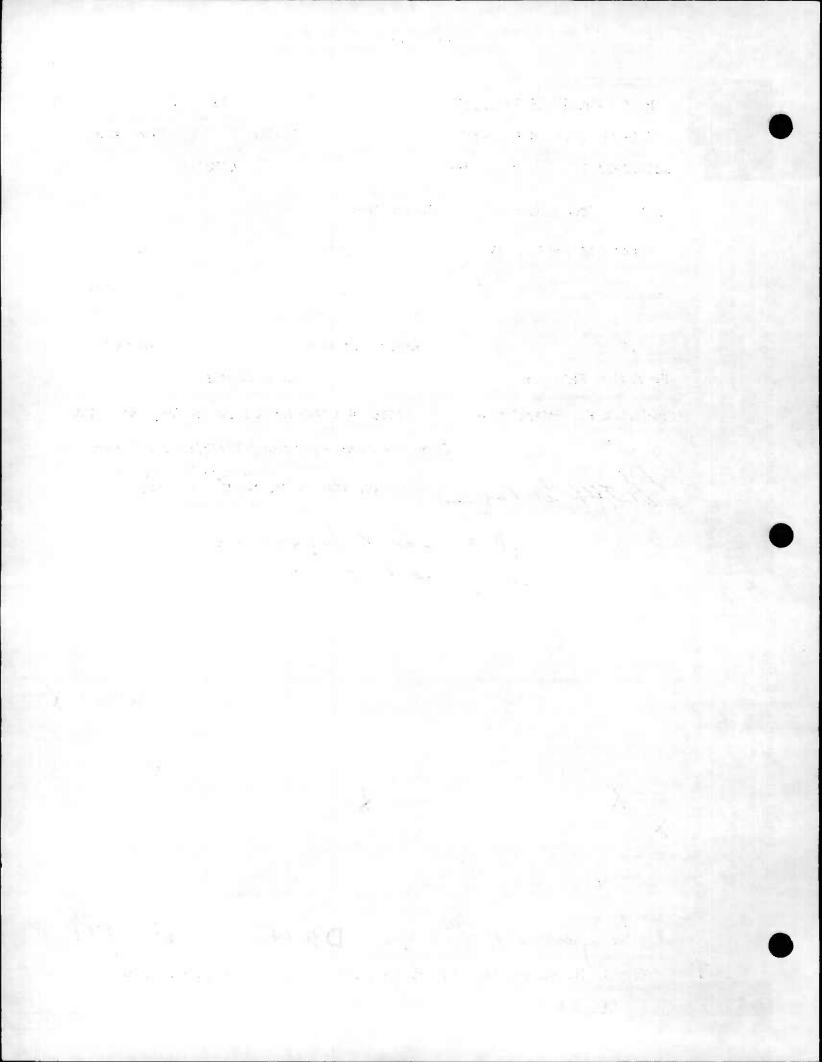
Brookellen Riden Racetrach 0.0. 11107 31. Data tilad (Month, Dey, Yaer) DEC 13 32. Registrar's Signatura 1999



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	State of Maryland / Department (Certificate 1. Decedant's Name (First, Middle, Last)			Reg. No.	40	5. Time of Death			
Physician /Medical	RUTH MARLENE PIELERT	A Ch Tour sal	Month 12	12	Yeer 99	1824			
Examiner	4e Fecility Neme (If not Institution, give street and number)	4b. City, Town, or L Berlin	ocation of Deeth	1					
	Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1		8 Data of Birth		cester	ce (State or Foreign			
Funeral Director	220-03-3716 Usual Residence of Decedent	Days Hours Min.	8. Data of Birt (Month, De) 8/28/1	y, Yeer) 7	Country	ce (Stete or Foreign y) PA			
and 41415-0020 be filed within 72 hours after death with the Maryland for the trans "natural", or terms 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location MD Worcester Ocean City				100	d. Inside City Limits 1 ☐ Yes 🎉 No			
of the death with the Mainteer death with the Mainteer and 23e or 28e-4 souther mainteer notified. Funeral Director	10e. Street end Number 10f. Zip Co	oda		10g. Citizen of	Whet Country	y?			
3a ov	13044 Old Bridge RD 21	842		USA					
deati rms 2		nt of Hispanic Origin? (Sp. Cuban, Mexicen, Puerto	pecify Yes or No-		a - American				
MING X 1X 13-0020 be filed within 72 hours after death with the Marylan be filed within 72 hours after death with the Marylan do other than "natural", or from 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 □ Yes 2 □		ricen, acc.)		ck, White, etc y: whit				
Maily Idel IO 2 12 13-0020 d 2 should be filed within 72 hours of h and Mental Hygiens and T le marked other than "natural; or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Kind of Busines								
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should Ind Mening Market	Frederick Eidinger 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (\$	Anna Streat and Numbar or Ru		or City or Town	State 7in C	(ade)			
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	Frederick E. Pielert/ Son 13038 OLc 20a. Mathod of Disposition 20b. Plece of Disposition (Name cametary, cremetory or other	d Bridge RI	Dete	20c. Location					
Dealtimore, permit. Pages 1 er Department of Heal Important: If Nem 2 any Injury or other once.	4 Donetton 5 Other (Specify) Cape Henlopen	Crematory	12/13/	99 Fran	kford	, DE			
Departiment in portion	V 1/1	Address of Fecility Bu	rbage F						
Physician /Medical Examiner	23a Part Enter the disease or complications that disease the ceath. Do not enter the mode of shock, or heart failure. This only one cause or each line. Immediate Ceuse (Final disease or condition resulting in deeth) Due to (price e consequence of):	of dying, such es cardiac	or raspiretory er	rest,	10	Approximete ntervet Between Onsat end Deeth			
A COLOGO, artificate be executed ling physician and e es the burial-transit Medical Examiner	Sequantially list conditions, if any, laeding to immadiate ceuse. Enter Underlying Cause (Disaase or Injury that Initiated evants rasulting in daeth) Last b. Dua to (or es e consequence of): c. Due to (or es e consequence of):	Faile	H						
v requires that the death certifications is should be detached for use as letted by Physiclan/Me	Part II. Other significent conditions contributing to death but not resulting in the underlying ceu	se given in Pert I.	23b. Did 1	tobacco use co	ontribute to t	he ceuse of deeth?			
that the ned by the detach			10	Yes 2□No	3 Proba	bly 4 Unknow			
				an autopsy med?	avail	a eutopsy findings lable prior to plation of causa eeth?			
Physician: The le runis certificate hes and director, page 2 n: To Be Comp			101	Yas 2 No	10	Yas 2□ No			
certificate rector, pa	25. Was case referred to medicet examiner?	26. Place of Dee	th (Chack only o	one)		٠.			
hysic his ce il dire	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 DOA	-	ome 5□ Resid	dance 6 □Ott	her (Specify)				
Affer the unera		: Injury at Work?	28d. Describe	now injury occu	rred				
but or Attending Physicien: rs efter death: at Director: After this certific ied in by the funeral director, Certification: To Be (Invastigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, or building, etc. (Specify)	1 ☐ Yes 2 ☐ No	28f. Location (S City or Tox	Street end Num vn, Steta)	ber or Rural i	Route Number,			
To the Heaplat or Attending Phywithin 24 hours about detect delth to the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	29a. Cartifier (Check only one) 29 Medicaf Examinar: On the bast of my knowledge, daeth occurred at 2 Medicaf Examinar: On the bests of exemination end/or investigation, in	the time, dete end plece my opinion, deeth occu	, and dua to tha cred at tha time,	causa(s) and m date end place,	annar as stai	ted. he ceuse(s)			
ithin 2 or the omple	ond mainter stated.	Journal License number		29d. Data signe	ed (Month, De	ey, Year)			
F 3 F 8	Juniamin H Men!	30743		12/1	3/9	9			
7	30. Name and address of derson who completed cause of death (Item 234 (Type, Print) Bejamin H. Meyer, MD 400 Eastern Sho	ore Dr. Sal	isbury.	MD 21	1801				
State Registrar		nks							

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Yea **Physician** LILLIAN LORETTA PRYOR DECEMBER 6 1999 8:11 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL ALLEGANY CUMBERLAND H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
AUG 25 1924 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country)
 MARYLAND 5. Social Security Number **Funeral** 10 M 20XF Days Yrs. 212 24 0370 75 Director **Usual Residence of Decedent** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f abov XX Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 HONEYSUCKLE LANE 21532 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status pemit. Pages 1 and 2 should be filled within 72 hours after c Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or then any injury or other traumatic event, are Heidler Examinations. 1 Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE Specify. 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 ARTHUR LANCASTER LEORA SIPPLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERRI BAKER, DAUGHTER 848 GREENE ST., CUMBERLAND, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) THE CUMBERLAND CREMATORY 12/7/99 CUMBERLAND, MD ins of Fungral Service Licenses 22. Neme end Address of Facilit SOWERS FUNERAL HOME, P.A. Xun 60 W. MAIN ST., FROSTBURG, MD 21532 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a/consequence of) P.O. Box 68760, Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ata has been signed by paga 2 should be datac 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificata of Vitai or Attending Physician: director. 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA this funeral To the Hospital or Attending Ph within 24 hours ettar death. To the Funeral Director: After th .. completely filled in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the or Medical (Check only one) iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D24951 DECEMBER 6 100 Urum O 30. Name and address of d cause of death (Itam 23a) (Type, Print) Lerrace Frostburg hana

Registrar **DHMH 16 Rev 6/95**

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State

31. Date filed (Month, Day, Year)
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32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 4 0 6 2 3

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Imberland iai Security Number 15-18-8679 Residence of Decedent tate 10b. County A. Itreet and Number 19 Arch St.: I Never Married 2 Man Widowed 4 Divorced (Specify any higha pentary/Secondary (0-12) I her's Name (First, Middla, Arley Morgal Arch St.: Arch St.: I Never Married 2 Man (Specify any higha pentary/Secondary (0-12) I her's Name (First, Middla, Arley Morgal Arch St.: I Secondary (0-12) I Commant's Name/Relations Open Commant's Name/Relations Open Command St.: I Command St.:	Rursing Ho 6. Sex 1 M 2 X 1 M 2 X 1 Legany 12. Was Deceder Armed Force 1 Year or Date: Year or Date: Coilege (1-4c) Last) an Thompson	Age (In yrs. last be 80 10c. City, To not Ever in U.S.	Yrs. Yr	If Under 1 Year Months Days ation mberlar 10f. Zip Code as Decedent of H Yes, specify Cubic Yes 27 No nt's Usual Occup and of work dona of NOT use refirer.	Cumber If Under 24 H Hours Mi Ad 2150 dispanic Origin? an, Mexicen, Pue Specify: Pation duning most of w	S. B. Date of Bin. B. Date of Bin. May. D. May	10g. Citizen of Whet USA 14. Race - Ai Black, W Specify: W	Allegany Birthplace (Stata or Foraige Country 10d. Inside City Limits 1
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treet and Number 19 Arch St: Invital Status Never Married 2 Man Widowed 4 Divorced (Specify only higha pentary/Secondary (0-12) Ither's Name (First, Middla, Arley Morga Informant's Name/Relations Dentity of Disposition Wirial 2 Cremation Donation 5 Other (S	reet 12. Was Decade Armed Force 1 □ Yes 2 □ If Yes, Give Year or Date: 15. Education st grada completed) College (1-4c) Last) an Thompso	nt Ever in U,S. strictly in the strictly in t	13. Walf Y	as Decedent of H res, specify Cube Yes 2 No n's Usual Occup nod of work dona O NOT use retirec	2150 lispanic Origin? an, Mexicen, Pue Specify: Pation duning most of w	(Specify Yes or Norto Rican, etc.)	USA 14. Race - Ai Black, W Specify: W	1 No Country? merican Indian, hite, etc.
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(1) (1	Specify)	20b. Piace cemat	of Disposition of Dis	tion (Nama of htory or other place	ca) . Cemet	Date er12/0!	20c. Location - City Cumberlome P.A.	or Town, State
Part 1. Enter the disease, or hock, or heart failure. List	complications that caus	sed the death. Do	C	Cumberl	and, M	aryland	21502	Approximate thereas Between
diate Cause (Final e or condition ng In death)	a	Ca.			th hair	wetasto	yes	6 worts
ntially list conditions, leading to immediate Enter Underlying (Disease or injury tiated events ng in deeth) Last	c	Due to (or as a						
Other significent condition	ons contributing to death	but not resulting	In the unde	erlying cause giv	en in Part I.	23b. Did	tobacco use contribu	ite to the cause of death
								Probably 4 Unknow
						24a. Was perf	an autopsy 24l ormed?	Were autopsy findings eveilable prior to completion of ceuse of death?
						10	Yes 2 No	1 ☐ Yes 2 ☐ No
s case referred to medice	Hospitel:			Oth	Ar: L	eath (Check only		
nner of Death Natural 5 Pendin Accident Investig	28a. Date of In (Month, L			28c. injur	y et k?	T		necity)
Suicide 6 Could in determine	ined 200. Place of I	Injury - At home, t etc. (Specify)	farm, street	t, factory, office		28f. Location (City or To	(Streat and Number or wn, State)	Rural Routa Number,
Check only 2 Medical one)	Examiner: On the basis and manner:	of examination a	nd/or Inves	stigetion, in my o	pinlon, death oc	curred at the time,	date and piace, end d	ue to the ceuse(s)
gnature and title of certifie	0.0	MD		29c. Licens	Y98/		Dec. S.	nth, Day, Year) 1999
peter 12			(Type, Pri	heley?	t. Cu	ubeila	d, Nd. 2	1502
on on	Yes 2 No ner of Death Natural 5 Pendir Accident Suicide 6 Could Homlcide 1 Certifyin neck only 2 Medical nature and title of certifie	Yes 2 No Hospitel: 1 □ Inpa ner of Death Natural 5 □ Pending Investigation Solicide Homicide 6 □ Could not be determined 28e. Place of building, If filer 1 □ Certifying Physician: To the best and manner and title of certifier The period of the period	Yes 2 No Hospitel: 1 Inpatient 2 ER/C ner of Death Natural Accident Suicide Homloide Accident Soulide Getermined Accident Soulide Homloide Accident Soulide Getermined Accident Soulide Gould not be determined Accident Soulide Gould not	Yes 2 No Hospitel: 1 □ Inpatient 2 □ ER/Outpatient ner of Death Natural Accident Suicide Homicide 1 □ Certifying Physician: To the best of my knowledge, death of and manner stated. Hospitel: 1 □ Inpatient 2 □ ER/Outpatient (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 28c. Place of Injury - At home, farm, stree 28c. Place of Injury - At home, farm, stree 28c. Place of Injury 28c. Place o	Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other of Death Natural Accident Suicide Homicide 1 Could not be determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time teck only and manner stated.	Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing ner of Death Natural Accident Suicide HomIcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pled and manner stated.	Yes 2 No	Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp. ner of Death Natural 5 Pending Investigation Solicide Homloide Sec. Injury - At home, farm, street, factory, office 28d. Describe how injury occurred Natural 5 Pending Investigation Solicide Homloide Sec. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred Natural 5 Pending Investigation Solicide Homloide Sec. Injury et Work? 1 Yes 2 No No No No No No No

James 1" Becare

686 8 6 034

State Registrar

212-327914

Riley Payne

5

nus

Zaman Johnson Heights, 625 Kent Avenue, Suite 102, Cumberland, MD 21502

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D0023371

December 8,1999

DUDE NA JAC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** Eugene C. Park Dec. 11, 1999 5:50 a.m. /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 15201 Haines Drive S.W. Cumberland **Allegany** 8. Date of Birth (Month, Day, Yeer) Jan. 3, 1925 If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplece (State or Foreign Country)
 TTT 7. Age (In yrs. last birthday) **Funeral X** M 2□ F Months Hours 236-28-0371 74 Yrs. Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other treumatic event, on Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MD Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15201 Haines Drive S.W. 21502 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tire Company lst Class Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Dennis Park Bessie (McBride) 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 15201 Haines Drive S.W. Cumberland MD 21502 Esta Park - wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from State 12/11 4 Donetlon 5 Other (Specify) Cumberland Crematory Cumberland, MD 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Scarpelli Funeral Home, P.A. Cumberland, MD Heurs caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset end Deeth **Physician** Supranuclear Palsy immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown Coronary artery disease þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? s certificate has I director, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, p Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) 1□ Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 10 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier edicai 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number

ms

Registrar

31. Date filed (Month, Day, Xeer)

PP JV, 912 Seton Drive; Cumberland MD
32. Registrer's Signature & Apacks

son who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

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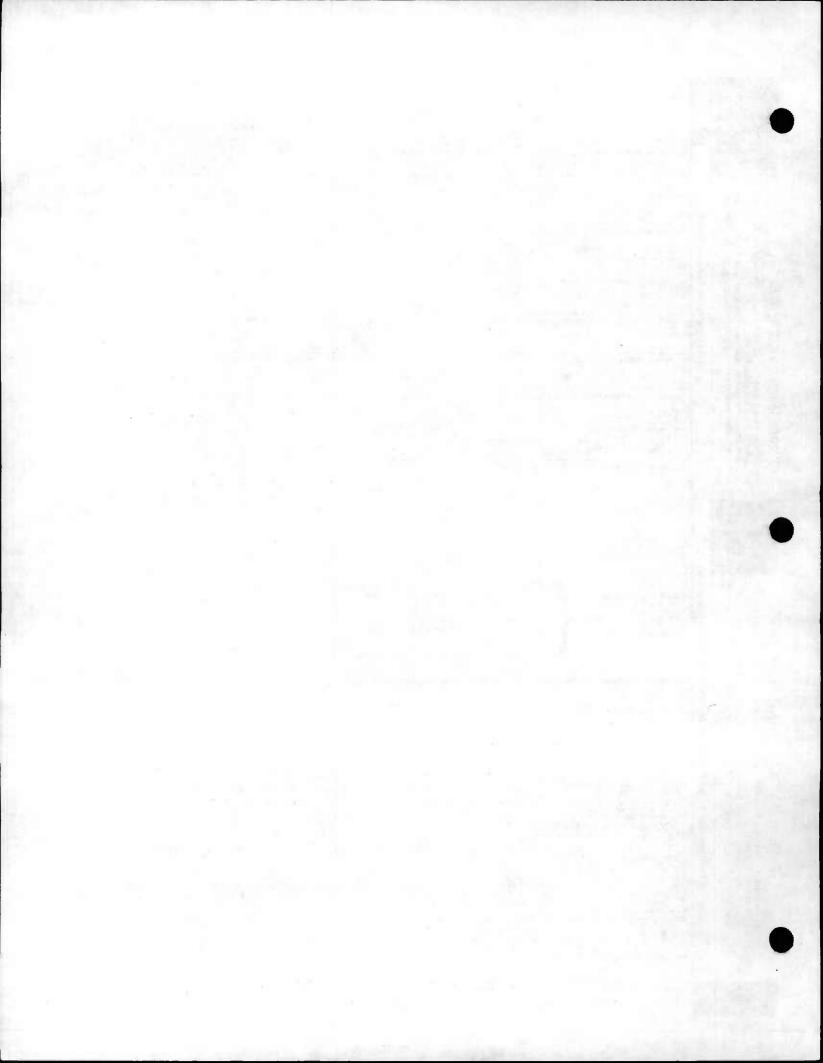
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State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** GLADYS LEOLA DEC 05, 1999 3:20 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUPPETT & WEEKS NURSING HOME OAKLAND GARRETT 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 82 Yrs. AUG 29, 1917 Director 220-22-7658 WV Usual Residence of Decedent r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Directo TATTI MINERAL ELK GARDEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 from traust be P. O. BOX 94 26717 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Pagas 1 and 2 should be filed within 72 hours after of ment of Health and Mentel hygiene.
Int. If I flem 27 is marked other than "natural", or the ury or other traumatic event, the Medical Emerical ury or other traumatic event, the Medical Emerical Control of the Control Contro 1 □ Never Married 2 □ Married 21215-0020 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 Maryland 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWARD HILES ARMEDA (UNKNOWN) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERA STONEBRAKER/CAREGIVER P. O. BOX 84, ELK GARDEN, WV Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Mathod of Disposition Data 20c. Location - City or Town, Stata permit. Pagas I Department of H Important: If Ne eny Injury or of page. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State I.O.O.F. CEMETERY DEC 08, 1999 4 ☐ Donation 5 ☐ Other (Specify) ELK GARDEN, WV 21. Signature of Funeral Service License 22. Nama and Addrass of Facility DAVID A. BURDOCK FUNERAL HOME undock 710 CHURCH STREET, KITZMILLER, MD 21538 Approximata Interval Between Onset and Death 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner congestive heart failure
Due to (or as a consequence of): years coronary artery disease 5 years The law requires that the death certificate be sescuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician tha buris Box 68760. Physician/Medical Dua to (or as a consequence of): for use signed by the sid be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown emphysema of Vital Records, þ 24b. Were autopsy findings available prior to complation of cause of death? page 2 should Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Othar (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funaral 27. Manner of Deat 28a. Date of tnjury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation or Attending 1 Naturel i efter death.

I Director: Aft in by the fur 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours of To the Funeral D' complately filled i Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number Kaunn D26650 12/5/1999 who completed cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Vear) Kaiser M. D. Hegistran's Signature 13079 Garrett Hgwy; Oakland, Md 21550 State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Month De **Physician** William Willis Redden December 14, 1999 2:35 PM /Medical 4e. Fecitity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Daeth Examiner Shore Nursing and Rehabilitation Denton 5. Sociel Security Number If Under 1 Yeer I tf Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F Months Yrs. Director 88 Feb. 20,1911 Maryland 217-36-0332 Usuat Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show 10d, Inside City Limits Director 1 ☐ Yes 2 No Maryland Queen Anne Queen Anne 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 313 Mason Branch Rd 21657 USA Was Decedent of Hispente Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Dacedent Ever in U,S Armed Forces? 11. Maritel Stetus 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: 21215-0020 Specify: White 1 ☐ Yas 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry ntal Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) 6 Grain farmer Agriculture Maryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other event eny Injury or other traumatic event 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William Hersey Redden Lillie Mae Willis 2 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Margaret Redden/ spouse 410 Colonial Dr Rm 408 Denton, Maryland 21629 Baltimore. 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Greensboro, Maryland December 17,1999 Greensboro Cemetery 22. Name end Address of Fecility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 23a. Pent1. Entar tha diseese, or complications that caused the death. Do not en shock, or heart feilura. List only one causa on aach lina. Approximete tntervel Betwean Onset end Deeth **Physician** punt Failure Immediate Ceuse (Final disease or condition resulting In death) /Medical wh Examiner Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasuiting in death) Lest bunal-tran be execu 68760 Physiclan/Medical ettending Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 ☐ Unknown by Records, page 2 should 24a. Was en eutopsy performed? 24b. Were autopsy findings evaileble prior to Completed peen completion of cause of death? this certificate has 1□ Yes 2 No Vital 1 TYes 2 No director. 25. Was casa raferred to medicat exeminer? Be 26. Placa of Daath (Chack only one) 20 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes of Mannar of Death 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred il or Attending P s effer death. I Director: After t Division 5 Pending Investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 2 4 Homicide stely filled in 24 hours Hospital 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the To the Comple 29b. Signature end title of contilion 29c. Licansa number 29d. Date signed (Month, Dey, Year) Washington St Eastern mo 2601 32. Registrer's Signature State Registrar

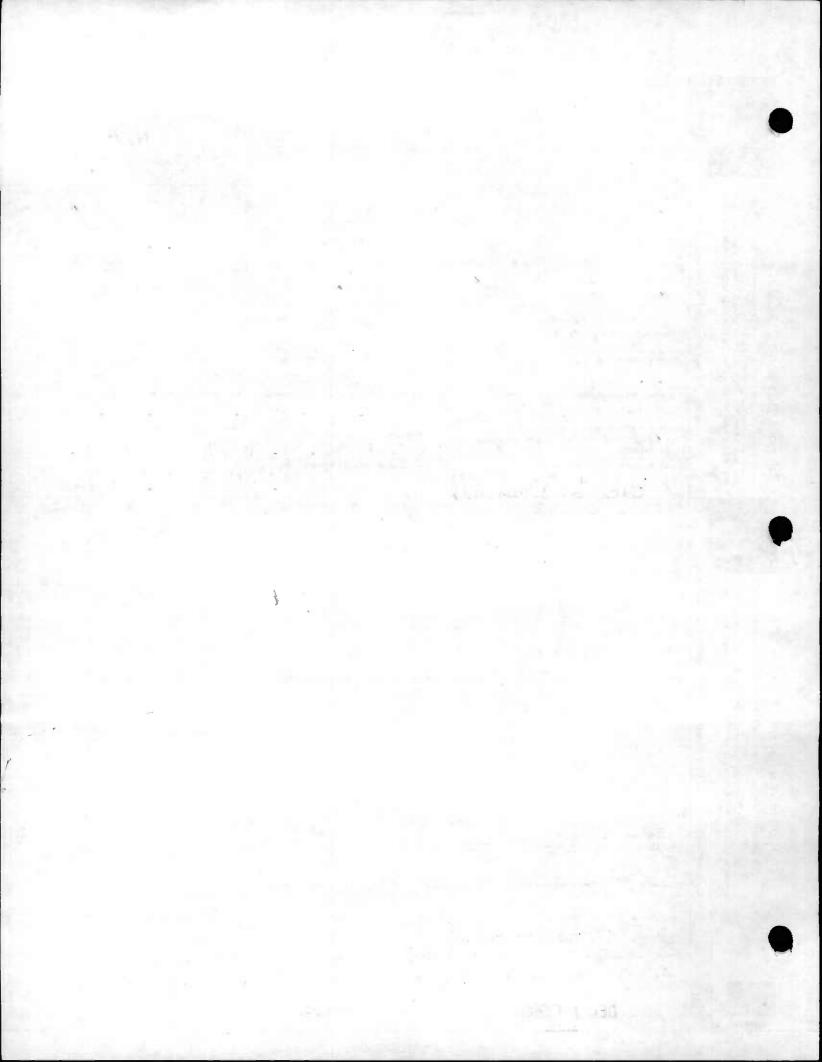
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State of Maryland / Department of Health and Mental Hygier 9 1, 0.6.2.8

HARRIET ROMERO DECEMBER 6 1999 02:45 Moderal	. atalaw	1. Decedent's Neme	(First, Middle, L	ast)			icate of		2. Dete of De Month	Reg. No.	Year	3. Time of Death	
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W. E. Mac key Semma of Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Paura Route Number. City or Town, Stele, Zp Code)		- the the	First, Middle, Las	t)		se ams	cress		leme (First, Middle				
19b. Maling Address (Street and Number or Rural Route Number, City or Town, Steet, & Code) Harriet Ford (Daughter) 25b. Maling Address (Street and Number or Rural Route Number, City or Town, Steet, & Code) 18 Buriel 2 (Cremation 3 (Demoustron Steet) 25b. Place of Disposition (Nume of cemelor), cereinoloy or other place) 12b. Signeture of Funeral Service Licensee 22c. Neme and Address of Facility 25c. Signeture of Funeral Service Licensee 22c. Neme and Address of Facility 25c. Signeture of Funeral Service Licensee 22c. Neme and Address of Facility 32c. East Ave. Easton, Md. 216 01 23a. Part. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory errest. Immediate Cause (Fine) 1 mediate Cause (Fine) 25c. Place of Death (Live and Street) 25c. Was cess referred to medical examinar? 25c. Place of Death (Live only one) 25c. Place of Death (Live one) 25c. Place o	ן נ	W.E. N	Mackey					Emma	Gibson				
20e. Nethod of Disposition 1			oer, City or Town,	Stete, Z	ip Code)								
It Buside 2 Cormation Capacity Commotory or other place)		Harriet	Ford	(Daughte	r) 25	512 N	N. Spa	ngler	St. Ph	nilia.	Pa		
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25. Wes cese referred to medical examinar? 25. Wes cese referred to medical examinar? 25. Wes cese referred to medical examinar? 26. Place of Deeth (Check only one)	pieten z										a	vailable prior to ompletion of ceuse	
25. Wes cess referred to medical examinar? 1	Son								10	Yes 2 No	1	☐ Yes 2☐ No	
27. Menner of Deeth 1 Nursing Home 5 Residence 6 Other (Specify) 28. Dete of Injury M Pari 28. Detection, office 28. Detection (Month, Day Year) 2 Accident 3 Suicide 4 Homicide 28. Plece of Injury - At home, ferm, street, fectory, office 28. Location (Street end Number or Rurel Route Number, City or Town, Stete) 29. Certifier (Check only one) 29. Signatura and titla of certifier 29b. Signatura and titla of certifier 29b. Signatura and titla of certifier 29c. License number RES - COO DECEMBER SIATH 1999			ed to medicel				la.		Deeth (Check only	one)			
1 Nature 2 Accident 3 Suicide 4 Homicide Standard Report Standard Rep	-		No	1 LA Inpati			L DON	4LJ NUISING			. ,	rify)	
29e. Certifier (Check only one) 29b. Signatura and titla of certifier 29b. Signatura and titla of certifier 29c. Certifier (Check only one) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 DECEMBER SIATH 1999	ification	1 🗀 Naturel 5 Pending (Month, Day Year) Injury Work? 2 Accident 3 Suicide 6 Could not be determined a could not be determined.										rel Route Number,	
29b. Signatura and titla of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 DE CEMBER SIATH 1999													
RES-000 DECEMBER SIXTH 1999		(Check only 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s)										stated. to the ceuse(s)	
Section 100 to the section of the se		29b. Signatura and t	titla of certifier	Ţ	MERN.)				29d. Date signe	d (Month	, Day, Year)	
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)			Sulome	h Keyha	M		RES	2-000		DECEMBE	R SI	ixth 1999	
		30. Neme end addre	ss of person who	completed cause of	death (Item 23a) (Type, Print)	The same	C. Carlott				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Dev Month **Physician** OLIVE RUTH ROBESON 10:00 AM DECEMBER 6 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Yeer | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) SEPT 25 1906 **Funeral** Months Devs Hours 10 M 2 F Yrs. 216 46 8785 93 MARYLAND Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Director ALLEGANY MARYLAND FROSTBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 100 HONEYSUCKLE LANE 21532 U.S. or itema 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Heelih and Mental Hygiel Important: if itam 27 is marked other th any Injury or other traumatic event, the BDGB. HOMEMAKER OWN HOME Baitimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fethar's Nema (First, Middla, Last) OTHO FIKE LINNIE WEITZELL 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) INA LEE DONIUS / DAUGHTER 11604 KEMP DRIVE, NW, FROSTBURG, MD 21532 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State ZION CEMETERY 12/9/99 4 ☐ Donetion 5 ☐ Other (Specify) GARRETT COUNTY, MD 22. Neme end Address of Fecility 21. Signeture of Funerel Service Licenses SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 23a, Pert1, Enter the or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, as only one cause on each line. Approximete Intervel Between Onset end Death shock, or heer Lie **Physician** Immedieta Ceuse (Finel diseese or condition resulting in deeth) PREUMONIA /Medical Examiner Physician/Medicai Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initieted events resulting in death) Lest the burial-tran Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20(No 3 Probably 4 Unknown EMENTIA should be det þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed page 2 s 1 ☐ Yes 22 No 200 No 1 Yes or Attending Physician: funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No Certification: To 1€Inpatient 2□ER/Outpatlent 3□ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 100 Neturel 5 Pending invastigation 1 Yes 2 No To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medicai 29a. Certifier

completely 10

nes

Quen 30. Nema and address of person who completed causa of deeth (Item 23a) (Type, Print) PAUL T. LIVENGOOD MD, 912 SETON DR, CUMBERLAND MD

32. Registrer's Signeture

29c. License number

123774

DECEMBER 7, 1999

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) DEC 0 9 1999

(Check only onel

29b. Signeture and title of certifier

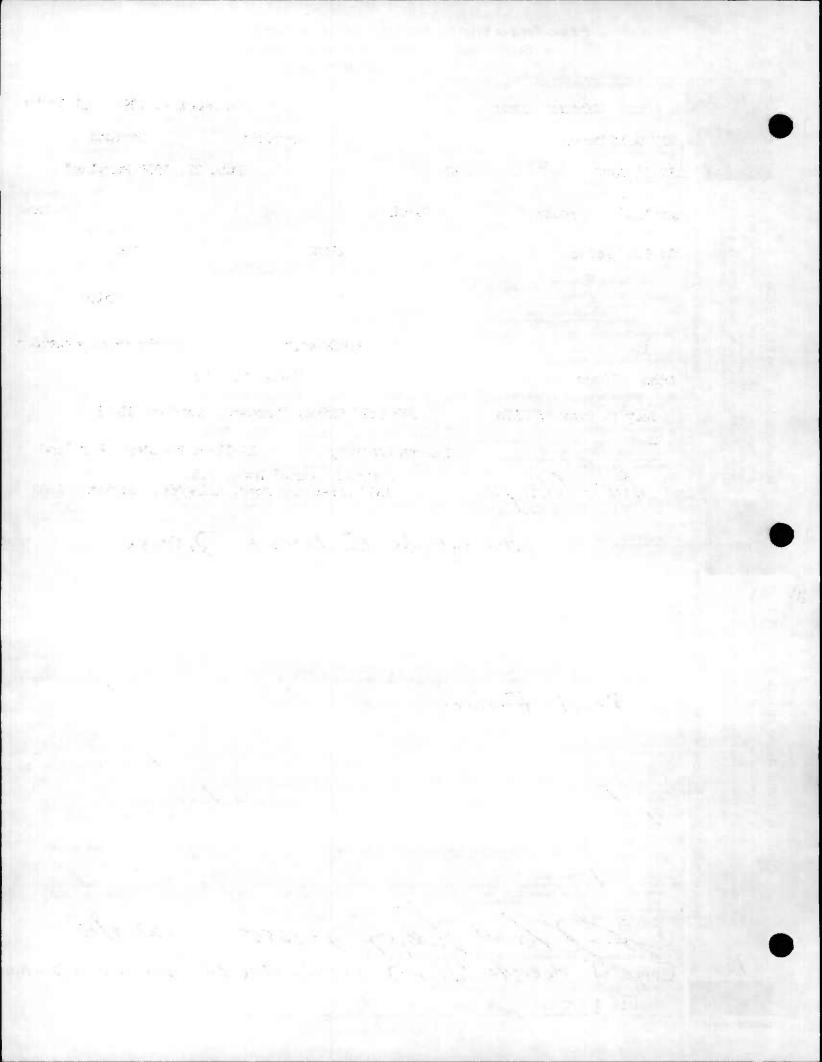
from the theretine

DOD! F. B. J. IL.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey Yee **Physician** December 8, 1999 11:10 PM /Medical Jess Webster Swain 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Aberdeen Harford 217 Golf Drive If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys M 2DF Yrs. Director 22, 1938 Maryland 217-34-0086
Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show Nom 27 is marked other than "natural", or frems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Harford Aberdeen Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21001 USA Funeral 217 Golf Drive permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mantal Hygiene.
Important if them 27 is marked other themany injury or other trauments. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Freight Transportation Truck Driver 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Mae Otho Oliver Swain Lee 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Golf Drive, Aberdeen, Maryland 21001 Judy E. Swain / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12-11-99 Aberdeen, Maryland Bakers Cemetery 22. Name end Address of Fecility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 plication, that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, one outsit on each line. Approximate Interval Between Onset end Death 23a. Part1. Enter the disease shock, or fleart failure. **Physician** Immediate Cause (Final disease or condition resulting In death) Cardiovascular Disease /Medical Examiner Examiner been signed by the attending physician and should be datached for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or injury Due to (or as e consequence of): Records, P.O. Box 68760 Physician/Medical that initiated events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: after daath. Director: After this certifica funeral director, Be 25. Was cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after da To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es steted. Medicai (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and fittle of certif 34085 m 30. Name and address of person who completed cause of death (ILem 23e) (Type, Print) 10 Plumpee Rd. Bel Air, us. D. 210/4 Acevedo Norge VIJA 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature State DEC Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95



			Please Type or Print in State of Maryl	land / D	k Indelible Ink Department of H Certificate of	Health and N	lental Hygie	ne	le.	neal		
	Physici /Medi		Decedent's Neme (First, Middle, Last) Raymond Eugene Silbaugh	oranoate or	Death	2. Date of Deeth November		999	3. Time of Deeth 7:45 PM			
	Examir		4e. Facility Name (If not institution, give street end number) 277 Maple Street			4b. City, Town, or Lo Friends	Deeth					
	Funeral Director		212-24-1712 1DM XDF 71	yrs. last birtl	hday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye			ece (State or Foreign ry)		
	Aaryland I show	or	Usuel Residence of Decedent	c. City, Town		iendsvill	0		10	od. Inside City Limits XX Yes 2 □ No		
	with the Maryland a or 28a-f show	I Director	10e. Street end Number 277 Maple Street		10f. Zip Code	.531		Citizen of Wh	net Count	****		
020	72 hours after death with the Maryland natural', or items 23a or 28a-f show ites Examine must be notified	by Funeral	11. Maritel Status 1 Never Married 3 Wildowed 4 Divorced 12. Wes Decedent Ever Armed Forces? 1 Yes, Give Year or Detes:	in U,S.		Hispenic Orlgln? (Specify Yes or Noban, Mexicen, Puerto Rican, etc.)			14. Race - American Indien, Black, White, etc. Specify: White			
21215-0020	c - #	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	1 - 1	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	during most of work	ing 16b	. Kind of Busi	iness/Ind	ustry		
nd 21	al Hyg other	Be Con	12 17. Fether's Neme (First, Middle, Last)		Sawyer	18. Mother's Nem	Lumber iden Sumeme)					
Maryland	should nd Men merke umatic	To	Albert Silbaugh 19a. Informent's Name/Reletionship (Type, Print)	19b.	Meiling Address (Street	Bessie Marie Artice (Street end Number or Rural Route Number, City or Town, State, Zip Code)						
	1 and 1 ealth		Ilene P. Silbaugh/Wife 20a. Method of Disposition 20	Ob. Place of I	P. O. Box 302, Friendsville, MD 21531 lace of Disposition (Name of Date 20c. Location - City or Town, Stet							
Baltimore,	ent on the H				eele Cemetery, Nov. 30, 1999 Friendsville, MD							
Ba	Departm Departm Importar any injur		21. Signature of Fungray Service Licensee		22. Name end Addre	Address of Fecility Newman Funeral Homes, P.A. Ller St, PO Box 275, Grantsville, MD 2153						
	Physician		23e. Part1. Enter the distance or compilications that caused the caused shock, or heart failure. List only one cause on each line.	deeth. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiretory errest,			Approximete Interval Between Onset end Deeth		
3	/Medical Examiner	<u>-</u>	resulting in dee(ii)		Lung Cancer onsequence of):	Non-smal	l Cell			2 months		
,	e executed lan and unal-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying	to (or es e co	onsequence of):							
09/89 x	certificate b iding physic ise as the b	/Medical	Ceuse (Disease or Injury	o (or es e co	onsequence of):							
7	vital meconds, r.o. inclan. The lew requires that the centificate has been signed by the rector, page 2 should be detached.	by Physician/M	Pert II. Other eignificent conditions contributing to death but not					ntribute to the cause of death?				
ecord		Completed t	Osteoarthritis, Diabetes Me	llitus	s, Type II		utopsy 1?	psy 24b. Were eutopsy findings aveilable prior to completion of cause of death?				
tal R			25. Was case referred to medical			00.01	1□ Yes No			1 ☐ Yes 2 ☐ No		
_ <		To Be	examiner? Hospital:	26. Piece of Deeti ner: 4 ☐ Nursing Ho	Deeth (Check only one) ng Home 55 Residence 6 □Other (Specify)							
ion of	ing After fune		27. Menner of Death 1 Naturel 5 Pending (Month, Day Year 28a. Date of Injury (Month, Day Year	2 ER/Outp 28b. Tin Inj	me of 28c. Injury		28d. Describe how injury occurred					
Division	al or Attand s after death I Director: /	Certification:	3 C Suicide 6 Could not be	At home, ferr	m, street, fectory, office	1		Location (Street end Number or Rural Route Number, City or Town, State)				
	Mospital or Att	dical	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of exemend menner steled.	knowledge, nination end	ne, date end piece, end due to the ceuse(s) end menner es steted. pinion, deeth occurred et the time, dete end place, end due to the ceuse(s)							

State Registrar 31. Dete filed (Month, Dey, Year) DEC - 2 1999

29b. Signature end title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser, M.D. 13079 Garrett Highway, Oakland, MD 21550

29c. License number

D26650

29d. Date signed (Month, Dey, Year)

11/29/99

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month DELBERT 12-14-1999 02:00PM 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SHORE NURSING & REHABILITATION CENTER DENTON CAROLINE If Under 1 Yaar If Under 24 Hrs. Months Deys Hours Min. 7. Aga (In yrs. lest birthday) 5. Sociel Security Number 8. Dale of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) 1**X** M 2€ F 222-03-0611 11-14-1912 SYRACUSE, N.Y. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X☐ No MARYLAND TALBOT NEWCOMB 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. BOX 21 21653 U.S.A. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Yaer or Dates: 1942–1945 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorcad WHITE 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 MANTANCE C.R. SCHOOL DIST. STATE OF DELAWARE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) N/A 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) DONALD HINSHAW P.O. BOX 21 NEWCOMB, MARYLAND 21653 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) DELAWARE VETERANS MEMOIRAL 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) BEAR, DELAWARE 12-17-1999 21. Signature of Funeral Servica Licensas TRADER FUNERAL HOME INC. 12 LOTUS ST. DOVER, DELAWARE 19901

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

Director

Funeral

Completed by

Be 2

N/A

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen Depertment of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innoral director, page 2 should be deteched for use as the buriel-transit Be Completed by Certification: To

Division of Vital Records, P.O. Box 68760,

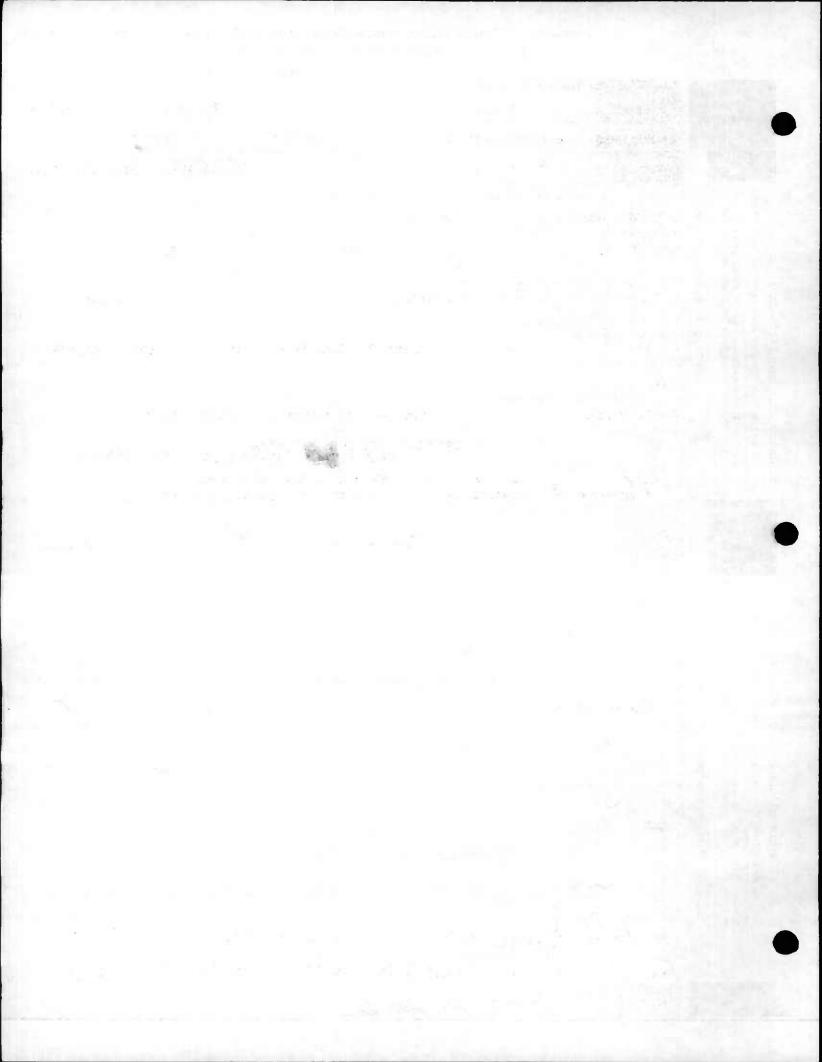
shock, or heert feilure. List only	nplicetions that caused line dea y one cause on each line.	ih. Do noi anter iha n	node of dyln	g, such as cardia	c or respiretory erras	1,	Interv	oximate vel Between et end Deeth					
Immediate Ceuse (Final disease or condition		1	1										
resulting in death)	eDue to (or es e consequenca	of):										
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	С.	b. — Due to (or es e consequence of):											
resulting in death) Lest	Dua to (or as a consequenca (of):				1						
Pert II. Other eignificant conditions Democracia	contributing to death but not re-	sulting In the underlyin	g cause give	n In Pert I.	23b. Did tobe		ontribute to the c						
				41	24e. Was an operforme	eutopsy ed?	24b. Were eur aveileble completi of deeth?	prior to on of causa					
					1 ☐ Yes	2	1 ☐ Yes	2□ No					
25. Was case refarred to medical examiner?	Hospital: Check only ona)												
1 ☐ Yes 2 ☐ Mb	Hospital: 1 ☐ Inpatient 2 ☐	a 6 □Oth	ner (Specify)										
27. Menner of Death 1	28e. Date of Injury (Month, Day Year)	28b. Time of injury M	28c. Injury Work 1 🗆 `	et (? ′es 2 □ No	28d. Describe how	Injury occur	rred						
3 Suicide 8 Could not determined		nome, farm, street, fec	28f. Location (Stre City or Town,	28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)									
29a. Certifier (Check only one) Certifying P Certifying P	hysician: To the best of my kno minar: On the basis of axemina end manner stated.	owledge, deeth occurration and/or investiget	ed et the tim ion, in my op	e, dete end pleci inion, death occi	e, end due to the ceu- urred at the tima, data	se(s) end me a and place,	enner es steted. and due to the ca	ause(s)					
29b. Signature and title of pertilier	Swams		29c. License)320	- ^		d (Month, Day,)						
30. Name end address of person who	completed cause of death (Ite	m 23e) (Type, Print)	uh 1	dive	Chesher	MO	2161	9					

32. Registrer's Signeture

State Registrar

Medical

Dete filed (Month, Dey, Year)
DEC 1 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month 2 SAMPSON **Physician** FRANCES 2125 15. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Dorchester General Cambridge If Under 24 Hrs. 8 Hours Min. Hospital Dorchester If Under 1 Year Months Deys 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 20 F Deys Yrs 212-16-7045 Director Sept. 28, 1908 Maryland Usuei Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mentel Hygiene. Important if them 23 or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 2 PNo Directo Maryland | Dorchester East New Market 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? P.O. Box123 21631 Funeral USA Was Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indlen, Bieck, White, etc. 11. Maritel Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Some one else's home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be James Farrow Janie Chester 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Allen Sampson, Son 27 Chest Nut Terrace, BuffaloGrove, ILL, 60089 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Cemetery Mt.Zion 12/11/99 East New Market, Md. ture of uneral Service Licensee 22. Neme end Address of Fecility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 2160] 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shown, or heart feilure. List only one ceuse on each line. Approximete Intervai Between Onset end Deeth Physician Immediete Ceuse (Finel diseese or condition resulting In death) /Medical UROSEPSIS Examiner Due to (or es e consequence of): Examiner attending physician and I for use es the burial-transit The lew requires that the death certificets be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequence of): Physician/Medical that initieted events resulting in death) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Plete Heart BLOCK PERTROPHIC CARDIOMYUPATH signed by 1 Yes 2 No 3 Probably 48 Unknown ģ 8 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy certificate hes page 2 1 Yes 2 No 1 Tyes 2 No To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifica completaly filled in by the funeral director; Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 PNaturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture end title of cartified.

DEC 1 0 1999

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2 AURORA ST. SUITE ZA CAMBRIBGE, M) MICHAGE P. MORRAN, MS 32. Registrer's Signeture

29c, License number

36860

29d. Dete signed (Month, Day, Year)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

			Certificate of Death		Reg. No.	40634						
Dhamisian	1. Decedant's Nama (First, Middle, Las	1)		2. Data of De Month	ath	3. Tima of Death						
Physician /Medical	THOMAS E.	SHIPLEY		Decembe		99 3:46 PM						
Examiner	4a Facility Name (If not institution, giva	street and number)	4b. City, Town	n, or Location of Death	4c. County of	Death						
	MEMORIAL HOSP			ERLAND	ALLE	GANY						
Funeral Director	5. Social Sacurity Number 6. Se 30 11 - 12 - 7743	7. Aga (In yrs. last 76	birthday) If Under 1 Yaar If Under 24 Yrs. Months Days Hours	Min. (Month, Da		Birthplace (Stata or Foraign Country) PENNSYLVANI						
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with the Ma t or 28a-f a be notified	10e. Street and Number	ANI COM.	10f. Zip Code		10g. Citizen of Wha							
ms 23a or	123 CUMBERLAND	STREET	21502		USA	at Country r						
	11. Marital Status	12. Was Decedent Evar in U,S. Armed Forcas?	13. Was Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, I	n? (Specify Yas or No Puarto Rican, atc.)	14. Race - Black.	Amarican Indian, Whita, atc.						
Dy by	3 ☐ Widowed 4 🖾 Divorced	1 ∑ Yas 2 No 1943 If Yas, Giva Yaar or Datas: 1945			Specify:W							
I 21215-0 ed within 72 ho sygiene. ner than "natur nt, the Madical. Completed	15. Decedent's Edu (Specify only highast grad	ucation 1	6a. Decedent's Usual Occupation (Give kind of work done during most of	f working	16b. Kind of Busin	nass/industry						
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Maryland 2 d 2 should be filed a th and Mental Hygie 7 le marked other traumatic event, the	19a. Informant's Name/Ralationship (T)					ata Zia Cadal						
S 0 5 2 5	JEFFERY T. SHIP		9b. Mailing Address (Street and Number 715 LINCOLN STRE									
iore, Maryla ges 1 and 2 should to Health and Men if item 27 le marke or other traumatic	20a. Mathod of Disposition	20b. Place	of Disposition (Nama of	Date	20c. Location - Cit							
	1 ☑ Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Hemoval from State	tary, crematory or other place) KYGAP	DEC	T. T. V. T. O. T.	0.17.7						
Baltin permit. Pa Departmen important: eny Injury once.	Signatura of Funaral Sarvice Licens	VEL	ERANS CEMETERY 22. Name and Address of Facility	9,1999	FLINTST	ONE, MD						
Depart Perm	Douglas &	HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502										
	23a. Part1. Entar the disease, or composhock, or heart fallures List only o	lications that caused the death. I	o not enter the mode of dying, such as ca	ardiac or raspiratory a	rast,	Approximate Interval Between						
Physician												
/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death)	al nero scien	ate Cardiou.	Acula	descens	e lugges						
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68760, ifficate be ext g physician as the burial ledical Extending the control of	Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaase or injury that initiated evants	c										
. Box 6876(death certificate be e attending physicis of for use as the bur sician/Medical	rasulting in death) Last Dua to (or as a consequence of):											
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that the death certific ed by the attending p detached for use as	Tartin outer organization outering con	minuting to doubt but not resulting		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow								
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al Records, P.O. Boy The law requires that the death ce tale has been signed by the attendi page 2 should be deteched for us. Completed by Physician/				24a. Was	an autopsy 2 med?	24b. Wara autopsy findings available prior to						
law re law re law re law re law re las be						complation of causa of death?						
f Vital Revyelden: The lavyelden: The lav glicector, page 2 Go Be Comp	V A STATE OF			101	as 20 No	1 Yas 2 No						
Vital Publicate certificate irector, pag	25. Was casa raferred to medical axaminer?		26. Place o	f Death (Check only o	ne)							
	1 Yas 2X No	Hospital: 1 ☐ Inpatient 28 ER/	Outpatient 3 DOA Other: 4 Nurs	ing Homa 5 Rask	dence 6 Othar	(Specify)						
ng Pi her th nema	27. Namer of Death	28a. Date of Injury (Month, Day Year) 28t	Time of 28c. Injury at Work?	28d. Describe I	now injury occurred	/ occurred						
Attending or death. Attending by the fune liftcation	2 Accident invastigation		M 1 Yas 2 No									
Division of the or attending P is after death. I Director: After the in by the funers Certification:	3 Suicida 6 Could not be determined	28a. Place of Injury - At home, building, atc. (Specify)	farm, street, factory, office	28f. Location (S City or Tov	Street and Number (vn, State)	or Rural Routa Number,						
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	20a Cadillas at 77 a min											
To the Hospital Within 24 hours To the Funeral completely filled Medical Co	29a. Certifier 1 Certifying Physical Check only 2 Medicat Examination	ner: On the basis of examination :	ge, death occurred at the time, data and a and/or investigation, in my opinion, death	occurred at tha tima,	causa(s) and menn date and placa, and	ar as stated. I due to the causa(s)						
o the o the omple	29b. Signature and title of centiller	and manner stated.	29c. License number		29d. Data signad (/	Month, Day. Year)						
F 3 F 8		Houthon	1/2/2	22								
11	30. Nama and address of parson who co	pure to couna of death/ltem 23s	(Tune Plint)	1	DECEMBI	ER 9, 1999						
This	Solvenia and address of parson was	death (Item 23a	top (146	elous ()	Mel	21000						
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatura	1 1	- Comex	1100	0000						
Registrar	DEC 0.3 1999	Deneva	& doorfol									

DHMH 16 Rev 6/95

Registrar

Shipley, Thomas

from the spoons

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 11 per fh 6779 1/15/00yq 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Time of Death **Physician** Vincent Snyder DECEMBER 10, 1999 19:15 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 24 Hrs. If Under 1 Year 8. Date of Birth Jan 19, 1939 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 20 F 60 Yrs. 215-34-2624 Director Usual Residence of Decedent 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Cumberland MD Allegany 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 12302 Bowling Street 21502 USA 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 40 If Yes, Give 'natural', or lisma 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married Balltimore, Maryland 21215-0020 1□ Yes 2□ No Specify Specify: white 30 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Programmer Social Security permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: if Nem 27 is marked other any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank C. Snyder Agnes (Barnes) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 Mullen Street; Cumberland MD 21502 LeAnn Owens oreat niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 12/13 Cumberland, MD 21. Signature of Funeral Service Licensi 22Scarperiffuneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 mou fle (DO2 Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physicien end for use as the burial-trant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequenca of) 1 WK ney mouse a P.O. Box 68760, certificate be Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 3 Probably 4 NUnknown 1 ☐ Yes 2 ☐ No signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed cate hes t 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 20 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Commedical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Wedlcal Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and life of certifier 29c. License number 29d. Date signed (Month, Day, Year) uncia 8377 December / ,1999 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) Deton 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

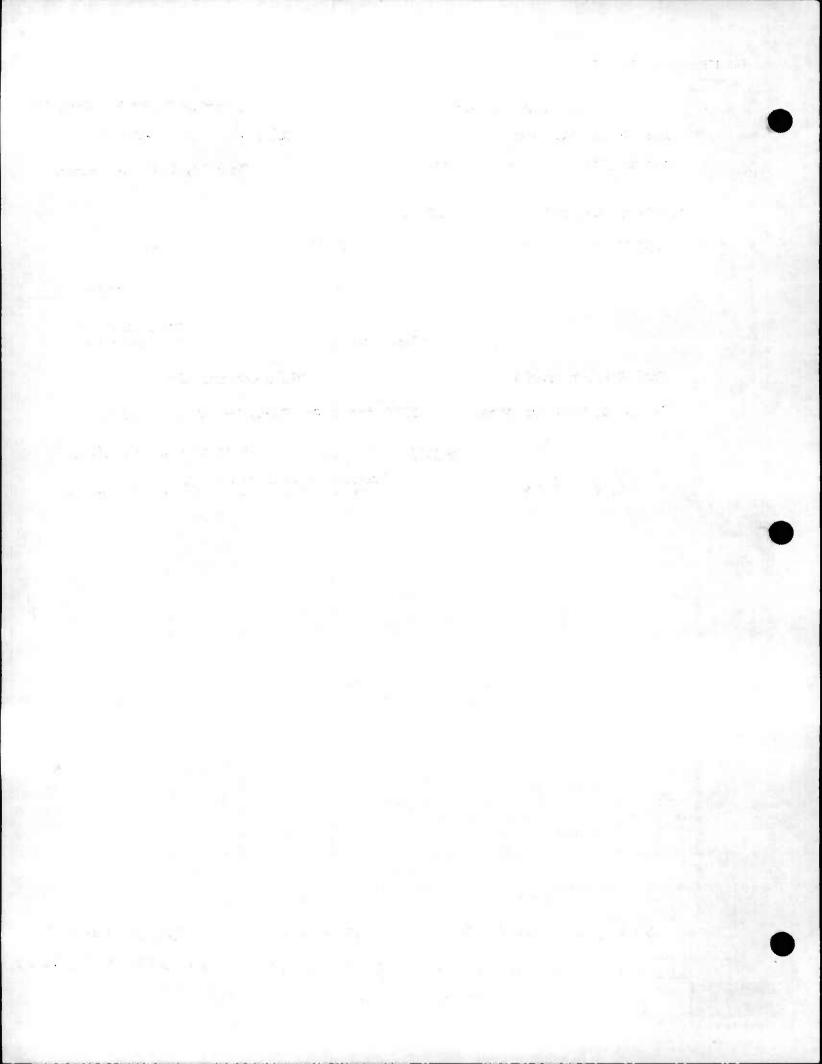
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene C Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 8:00 PM Ellen Ann TURNEY Nov. 29, 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Garrett County Memorial Hospital Oakland Garrett If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 SF 219-14-7411 Yrs. July 25, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 E. Mason Street 21550 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Yes 2 No if Yes, Giva Year or Dates: 1 M Never Married 2 ☐ Married 1 ☐ Yes 2 Po Specify: Specify: White 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highest grada complated) 16a, Dacedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Sales Clerk Clothing Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Newton Turney Elizabeth Little Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1980 Superfine Lane, Wilmington, Del. 19802 Elizabeth J. Brown/Sister 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/5/99 4 ☐ Donation 5 ☐ Other (Specify) Omega Crematory Morgantown, WV 21. Signatura of Funeral Sarvice Licansee 22. Name and Address of Facility Stewart Funeral Home Medito 32 S. Second St., Oakland, Md. 21550 Approximate Intarvai Batwean Onset and Death 23a. Part1. Enter the disease, or complications that ceusad tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Immediata Causa (Finat disease or condition resulting in death) Acute myocardial infarction immediate Dua to (or as a consaquance of): Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consequance of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed?

Physician /Medical **Examiner**

attending physician

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requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

* /Medical

Examiner

10a. Stata

Director

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item 27 la markad other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examples.

altimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medical þ Completed Be

shysician and the burial-trensit USe as the signed l page 2 funeral director, Certification: To

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic heart disease

1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Mannar of Death Naturai 5 Pending investigation

1 Inpatient 28a. Date of injury (Month, Day Yaar)

26. Place of Death (Check only one) ≥ ER/Outpatient 3□ DOA 28b. Time of Injury 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Describe how injury occurred

21550

1 Yes 2 No

29a. Certiflar (Check only one)

29b. Signature and titla of certifian

2 Accidant

4 C Homicida

3 Suicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

6 Could not be determined

29d. Date signed (Month, Day, Year) 0

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print)

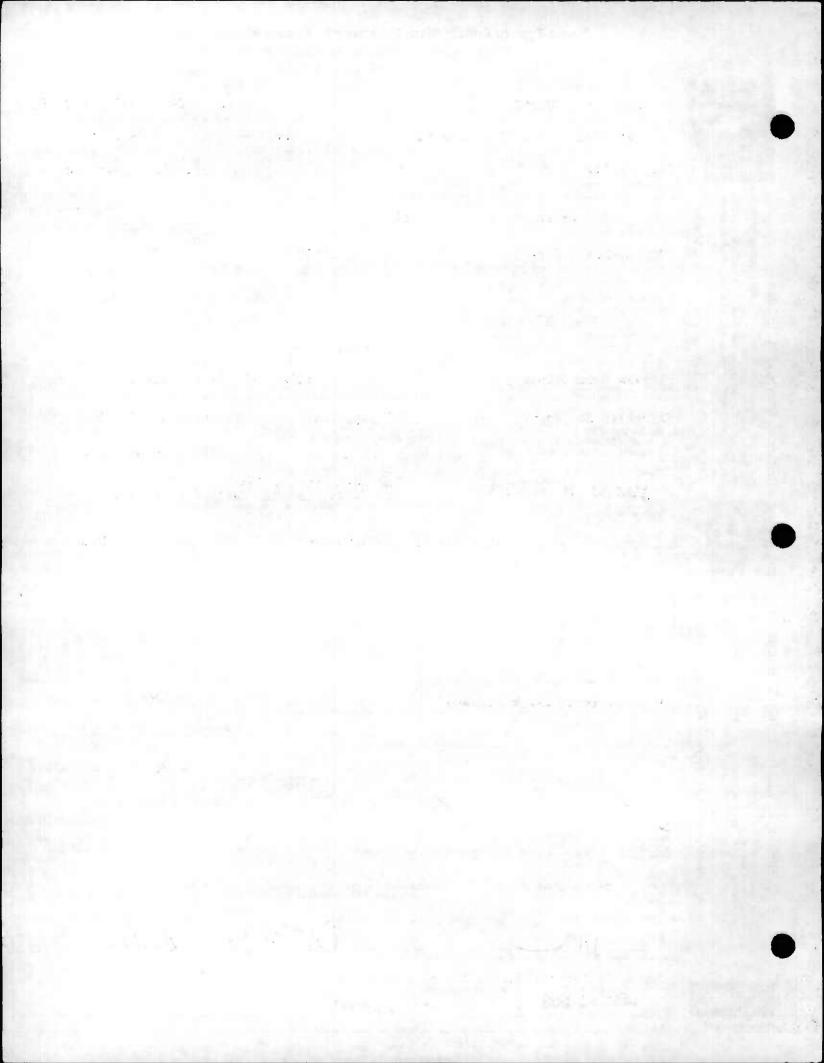
Thomas G. Johnson, M.D. 311 N. Fourth St Oakland, MD 31. Data filed (Month, Day, Year)

State Registrar

Medical

3. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40639 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Dey Mildred Sue Whitacre DECEMBER 2 1999 2:32 AM 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) 6. Sex 7. Age (In vrs. lest birthday) 1□M 2√F Months Yrs. Elk Garden WV 234 78 8242 Usuel Residenca of Decedent 55 Nov 1,1944 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No WV Elk Garden Mineral 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 26717 USA PO Box 500 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 1 ☐ Never Merried 2X Merried Specify: White 1 Yes 25 No Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) 10 Homemaker Housewife 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Edward C. Welch May Oates 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Milton Whitacre PO Box 500 Elk Garben, 20b. Placa of Disposition (Neme of cemetery, crametory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Kalbaugh Cem 22. Name and Address of Fecility ELK Gorden WV 12-4-99 21. Signature of Funeral Servica Licenses DAVID A. BURDOCK FH 710 Church St KIT undock 21538 KITZMILLEY MA 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only ona cause on each line. Approximete Intervel Between Onset end Deeth Immediata Ceuse (Finel diseese or condition resulting in death) 24 hours e Cardiogenic Shock Due to (or es e consequence of): Acute Myocardial Infarction 24 days Due to (or es e consequance of): Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic renal failure, hypoalbuminemia, 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

for use as the burial-tran

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After

24 hours after death. Funeral Director: Al

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Medical Certification: To

or Attanding Physician:

Hospital

The law requires that the death certificata be executed

234-78-8242, **P.O. Box 68760**,

Vital Records,

Division of

MILDRED WHITACRE

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: if frem 27 is marked other than "natural", or item any injury or other traumatic avent, the Hedical Fran

Baltimore, Maryland 21215-0020

Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Physician/Medical ģ Completed

Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I.

malabsorption syndrome

25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 № No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? 5 Panding 1 Natural 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide

29e. Certifian 1 Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, data and place, and dua to tha cause(s) and mannar es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha time, data and placa, end due to the cause(s) end manner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number

H-1000 30. Name end eddrass of person who completed cause of deeth (Item 23a) (Type, Print)

DR. N.A. RANJITHAN, 517 OLDTOWN ROAD, CUMBERLAND, MD

31. Dete filed (Month, Dey, Year) DEC - 6 1999 32. Registrer's Signeture

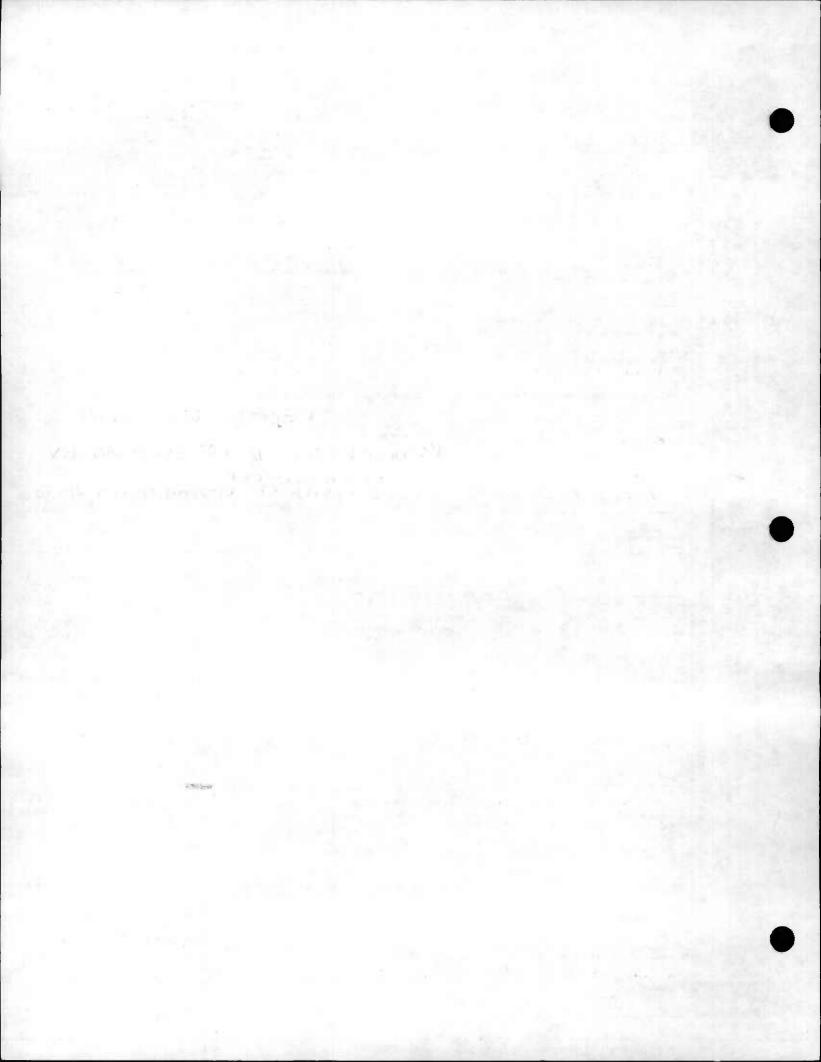
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DECEMBER

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Registrar DHMH 16 Rev 6/95

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Des Month **Physician** RACHEL WILLIAMSON 1999 16 2:58 AM Dec /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Talbot The Pines Easton Genesis ElderCare -8. Dete of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) Deys Months Hours 1 M 200 F 220-66-3704 Usuel Rasidence of Decedant Yrs. 109,18,1919 10a. Stete 10b. County 10c. Cify. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo MO CAROLINE FEDEYALSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21632 USA 103 AVE UNIVEYSITY Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOUSEWIFE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Sumame) Be FUZABETH THAWLEY HARUEY QUILLEN 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21132 19a. Informent's Name/Raletionship (Type, Print) PATYICIA JEANIE COHER-DAUGHTER 27351 (OUT) PEDECHASBURG, MO 20b. Pleca of Disposition (Neme of cemetery, crametory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Ramovel from Steta HILLEYEST 12/19/99 CEMETERY FEDERAS BURG MD 4 □ Donetion 5 □ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility FUNEVAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart feitura. List only one causa on eech line. tmmadiata Causa (Final VASCULAR ACCIDENT diseasa or condition resulting in death) Examiner PERTENSION Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in death) Lest NON-INSULIN DEPENDENT DIABETES MELLITIS Physician/Medical Due to (or es a consequenca of INSUFFICIENC Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Placa of Death (Check only one) 23 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? Certification: 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accidant

P.O. Box 68760 or Attending s after death.

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f sho other traumstic event, the Medical Examiner must be notified at

Hygiena.

permit. Pages 1 and 2 should be filed will Department of Health and Mantal Hygien, important: If frem 27 is marked other that any flury or other traumetic event, the phose.

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Pages 1 and 2 should be filed within 72 hours after

Williamson, Maryland 21215-0020

altimore,

Rachel

Records, Division of Vital 24 hours a

> State Registrar

DANIEL E. MAKAS, 00 31. Dete filed (Month, Dey, Year)

DEC 1 7 1999

30. Nama end addrain of person who completed gause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifian

4 Homicida

(Check only

29b. Signature and title of cert

508 INEULD AVE 32. Registrer's Signeture

MARAS

28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

1 Certifying Physician: To the best of my knowledga, daath occurred et the tima, deta end piece, and dua to tha ceusa(s) end menner es steted.

2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the causa(s) end member steted.

29c. License number

EASTUN

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40641

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					ial Hos					Eas			Ta	lbot		
ı	Funeral Director	2	ocial Security N	3357	6. Sax 1 M 2 □ F	7. Aga (In yrs. 81	last birthday) Yrs.	If Under 1 Months	Days	If Undar	24 Hrs. Min.	8. Data of Bir (Month, Da March 3	th 19, Year) 0,1918	9. Birtht Cour Mary	olaca (Stata or Foraign olty) Land	
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is	Atte octo											28f. Location (on (Street and Number or Rural Routa Number,			
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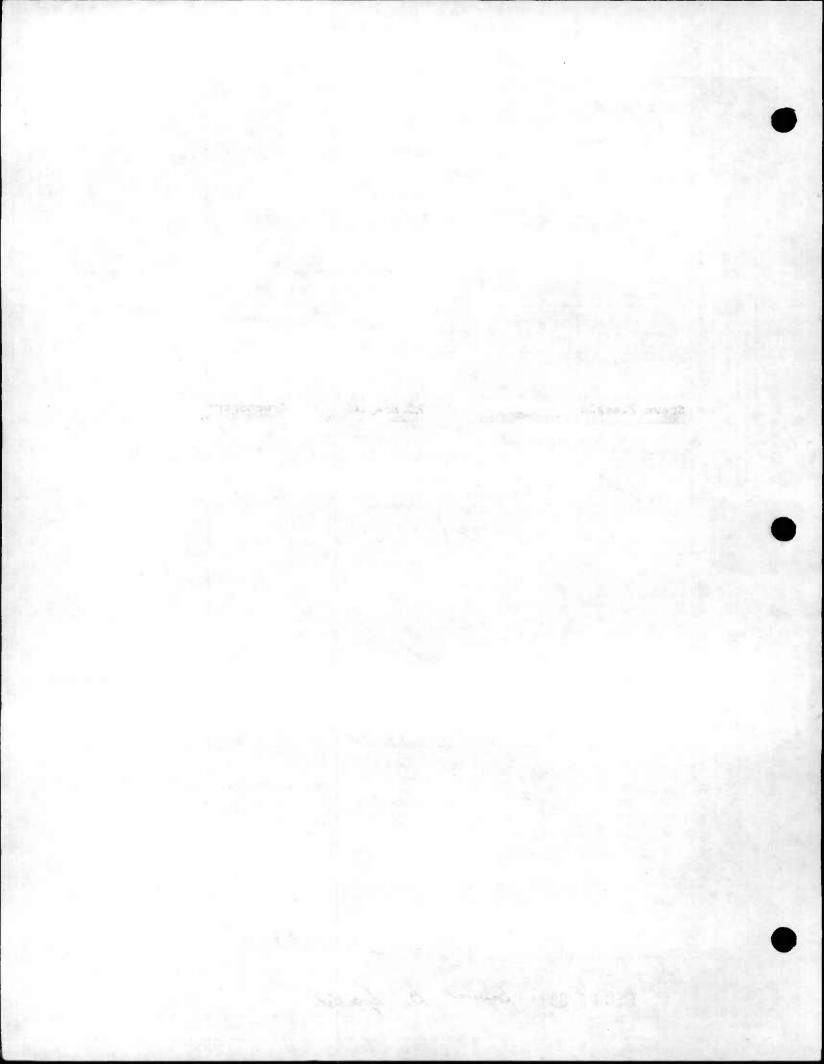
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Russell A. Schilling DO

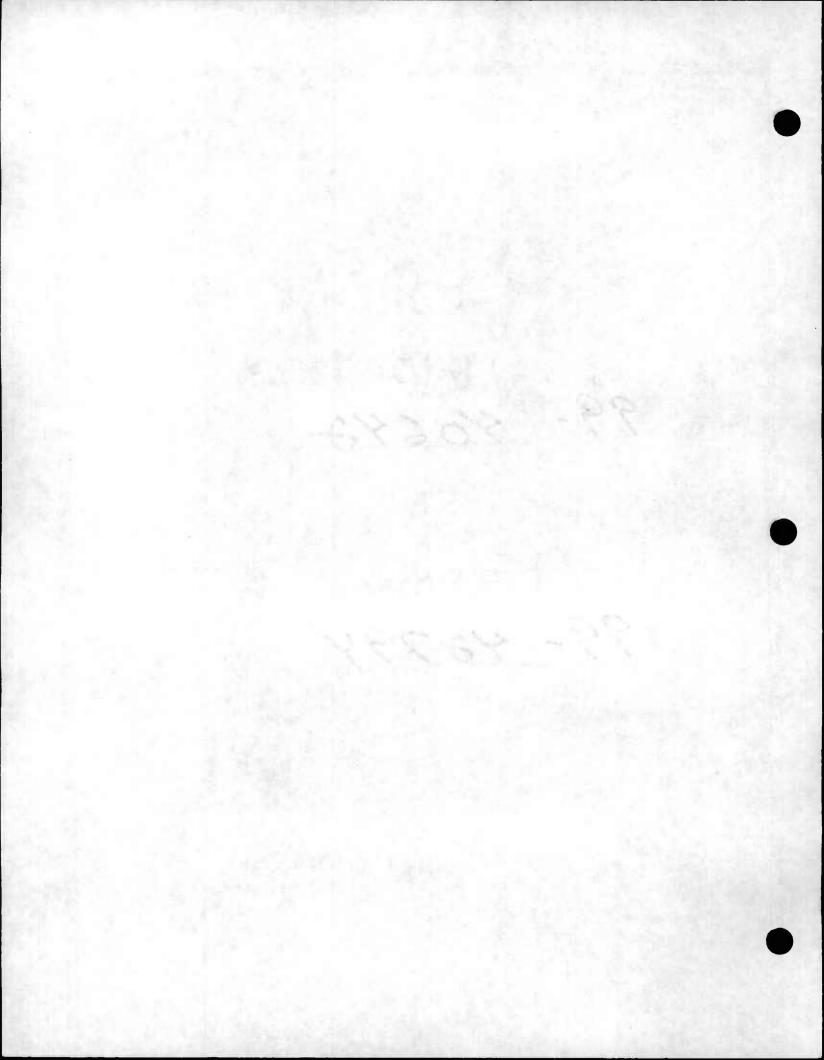
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Tima of Death Dav Month Year **Physician JOANN** R. /Medical NOVEMBER 29 1999 0112 AM 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital **Cumberland** Allegany Birthplace (Stata or Foraign Country) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Yrs 236-36-2161 Director 74 Nov. 22, 1925 Ohio Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth end Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23s or 28s-f show any highry or other traumatic event, fro Medical Examiner must be notitled an once. 1 Yas 2 □ No Director WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 Center Street 26726 Funerai USA 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 M No If Yes, Giva Yaar or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marilel Stalus 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: á Specify: 3 XWidowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Harold T. Kessel Zerna F. Smith 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 326 "D" Street Joseph W. Kessel/Brother Keyser, WV 26726 20b. Place of Disposition (Name of camatary, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State Deta 1 Burial 2 Cramation 3 Removal from Stata Dec. 2 4 ☐ Donetion 5 ☐ Othar (Specify) Queen's Point Cemetery 1999 Keyser, WV 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Smith Funeral Home recen 85 S. Main Street 26726 Keyser, WV 23a. Part1. Enler lha disaasa, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heer feiture. List only one ceuse on each line. Approximeta Interval Between Onset end Death **Physician** Immediate Cause (Final disaesa or condition rasulting in daath) /Medical a. METABOLIC ENCEPHALOPATHY Examiner 7 days Dua to (or as a consequence of) Physician/Medicai Examiner RENAL **FAILURE** unknown The law requires that the deeth certificate be executed the attending physician and thed for use as the burial-tren: Sequantially list conditions, if any, laeding to immadiata cause. Entar Undarlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. DIABETES MELLITUS unknown Dua to (or as a consequence of) HYPERTENSION unknown P.O. I Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA PERIPHERAL NEUROPATHY Records, il or Attending Physician: The law requires the after death.

Offector: After this certificete has been signe d in by the funeral director, page 2 should be a Be Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? CORONARY ARTERY DISEASE completion of cause of death? 1 Yas 2 X No 1 Yes 2 No Division of Vital 25. Was case rafarrad to medical 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Certification: To 27. Mennar of Death 28a. Dala of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 XNatural 5 Pending 1 Yas 2 No invastigetion 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 - Homicida Medicai 29a. Cartifiar 1 🔀 Certifying Physician: To the best of my knowledga, daath occurred et the time, data and place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signetura and title of monthless 29c. License number 29d. Data signed (Month, Day, Year) D0054004 1999 DECEMBER nama 6 30. Name end eddress of person who complated cause of deeth (Item 23e) (Type, Print)

Registrar

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State

SHIV KHANNA M.D.

31. Dete filed Empreth Pa 8 7 999

625 KENT AVENUE CUMBERLAND MD

30 Registraris Signeture

050 08 000 June & Louis

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Neme /First Middle Last 2. Date of Death Month **Physician** WILLIAM KENNETH WINFIELD /Medical **DECEMBER 10, 1999** 05:15 A.M. 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND If Under 24 Hrs. 8. Hours Min. D SACRED HEART HOSPITAL ALLEGANY If Under 1 Year 9. Birthplace (State or Foreign MARYLAND 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) DEC 25 1932 7. Age (In vrs. last birthday) **Funeral** Months Deys MM 20 F 217-28-9050 66 Yrs Director Usual Residence of Decedent 10a. Stete 10h County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Director MARYLAND CUMBERLAND ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 33 BEACHWOOD DRIVE 21502 U.S.A. 238 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Let Yes, Sive Yes, Give Yes or Detes: Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? Armed Forces? It Yes, Specify: Yes or Detes: CHARD 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican Market Page 1. The Property of The Prope Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 6 Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced GUARD 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) KELLY SPRINGFIELD TIRE CO MANUFACTURE TIRES 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be nd Mental I WILLIAM JOSEPH WINFIELD MABEL LEONA YEIDER and a 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 is any injury or other tras MARTHA G. WINFIELD WIFE 33 BEECHWOOD DRIVE CUMBERLAND MARYLAND 21502 20b. Plece of Disposition (Neme of cemetery, cremetory or other p 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete SUNSET CEMETERY DEC 13 1999 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funerel Service Licen 22. Neme end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one ceuse on each line. **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Zonono 6 Examiner Due to (or es e consequence of) Physician/Medical Examiner The lew requires that the death certificete be axecuted ed by the ettending physician and detached for use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 10 168 2 No 3 Probably 4 Unknown Records, À Be Completed 24b. Were autopsy findings eveilable prior to 24a. Wes en eutopsy performed? After this certificate has been completion of cause of death? aronary 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ne Medical Certification: To 1 Dationt 2 ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner plated. 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) DECEMBER /U cause of em 23a) (Type, Print) hus

DHMH 16 Rev 6/95

State Registrar egistrer's Signeture

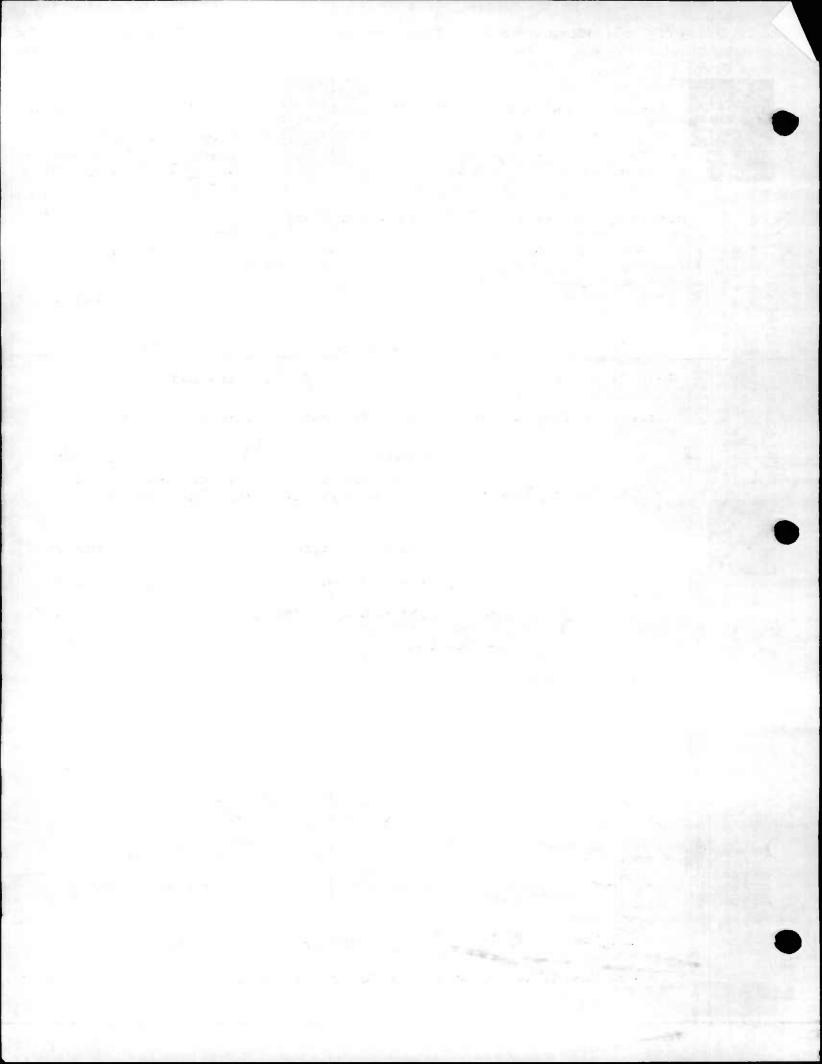
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C. Alberton Donald Tests to Park

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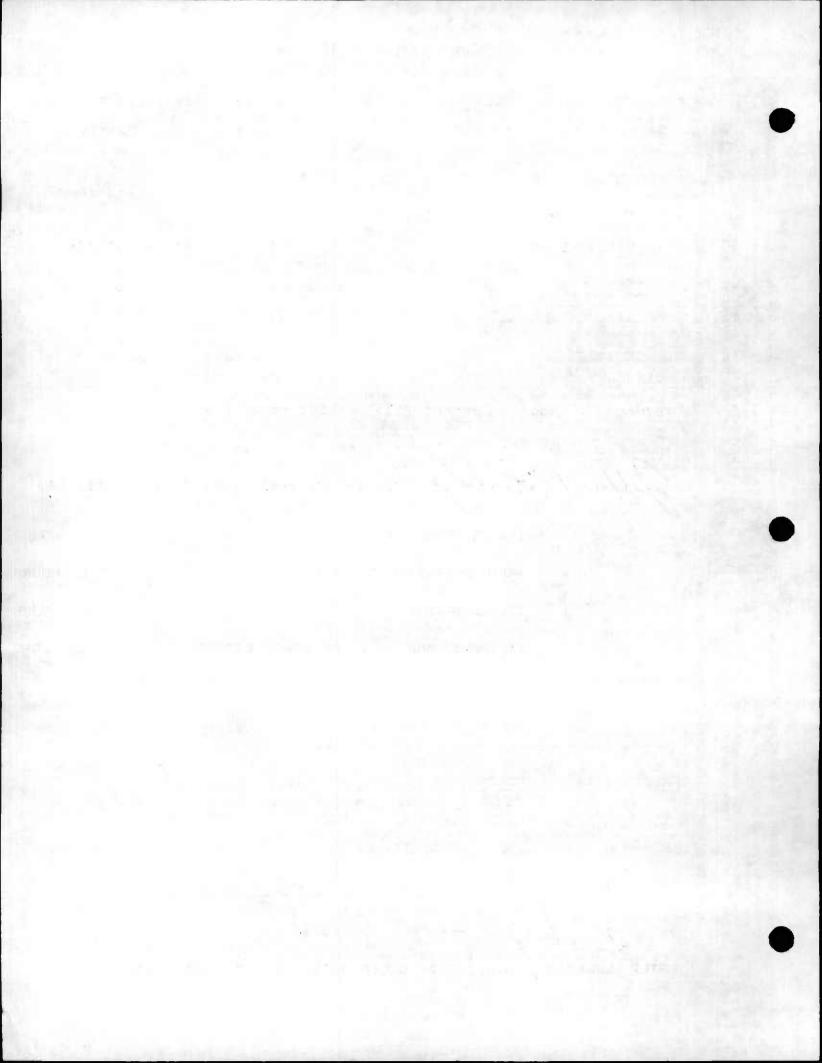
			tate of Marylan	d / Depa	rtment o tificate	of D	ealth an	d M		leg. No.	3 4	0646
Physic /Medi		1. Decedant's Nama (First, Middla, Last) Margaret Louise		illis					2. Dete of Dea Month Dec . 9	Day 199		3. Tima of Deeth 6:50 pm
Exami	ner	4a. Facility Nema (If not institution, give street 112 Railroad Av							cation of Death	4c. County		er
Funeral Director		5. Social Security Number 6. Sex 214-07-7628 1□ M	2X F 7. Aga (In yrs. 81	last birthday) Yrs.	If Undar 1 \ Months D	rear	If Undar 24	Hrs.	8. Data of Birth (Month, Dey June 3	Year)	9. Birthp	laca (State or Foreign
yland		Usuai Rasidence of Dacedent 10a. Stata 10b. County	10c. City	y, Town or Lo	cation				1		1	0d. inside City Limits
2 4 F	Director	Maryland Dorches 10e. Street and Number	ter	East 1			et					1 ☐ Yes 2X No
Za or with		112 Railroad Ave			10f. Zip Co	2163	31			log. Citizan of \	S.A.	
20 %	by Funeral	1 Nevar Married 2 X Merried	Armad Forcas? 1 □ Yes 2 X No		Vas Decedan Yas, specify	Cuban,	panic Origin Maxican, P	? (Speruanto F	cify Yas or No- Rican, atc.)		ca - Amaric ck, Whita,	etc.
Maryland 21215-0020 d 2 should be filed within 72 hours ah th and Mental Hygiene. The marked other than "nehural", or traumatic event, the Medical Exami	Completed b	3 U Widowad 4 U Divorced 15. Decedant's Educatic (Specify only highest grada col	'aar or Datas: n npleted)	16a. Decedant's Usual Occupation (Giva kind of work done during most of work: life. DO NOT usa retired)					ng		of Businass/Industry	
1 212 led vith tygiens her than	Com	12	Coliaga (1-4or 5+)		atelo	g c	lerk					sales
ylanc Mental H Mental H mred of	To Be	17. Fethar's Name (First, Middla, Last) John E. Burton							(First, Middla, I		na)	
Aary 2 shou and N is man		19a. Informant's Name/Ralationship (Type, I	Print)	19b. Mailin	g Address (S				Route Numba		Steta, Zip	Coda)
Heal Item 2		Harry P. Willis/ 20a. Mathod of Disposition Buriai 2 Cramation 3 Ramo	20b. P	P.O laca of Dispos amatary, cram	ition (Nama	of	l, Cá	amb	ridge,	MD 2.		wn, Steta
Baltimore, pemit. Pages 1 at Department of Hea Important: If Item 3 any injury or other once.		4 □ Donation 5 □ Othar (Specify) 21. Signature of Funeral Salvice Licensee		C	Nama and A	ddrass	of Facility	1	2-14 Funera	Cambr	o D	λ
Physician		23a(Part). Enter the disease, or complication shock, or heart failure. List only one can	ns that caused tha daeth usa on aach lina.	a. Do not ante	08 Hic or tha moda o	gh.	St., such es car	_Ca	mbrido raspiratory arr	e, MD	216	1.3 Approximata Intarval Between Onsat end Death
/Medical Examiner	.	Immediata Cause (Final disease or condition rasulting in death) a	cerebrova Dua to (o	scula:		ide	nt					months
58760, Icate be executed physician and s the bunal-transit	Examiner	Sequantially list conditions, if any, laading to immedieta	uance of):	disease nce'of): nt diabetes					yea			
	Medicai	Causa (Disease or injury thet initiated events rasulting in deeth) Last	ence of):							years		
Geath cert death cert e attending of for use	Ician	Dort II Other algoritisms and distance continue		let a facility	4.44.							
P.O net the od by th	by Physician/M	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.						_	23b. Did tobecco use contribute to the cause 1 Yes 2 No 3 Probably 4			the cause of death?
aw requir	Completed								24a. Was a perform	n eutopsy med?	COI	are autopsy findings aliabia prior to mpiation of causa daath?
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of Vita Physician: this certific	To Be	25. Was casa rafarred to madical axaminar? 1 Yas 2 No Hospi	el: 1 Inpatiant 2 I	ER/Outpatient	3□ DOA	Other:			(Chack only on		er (Snecih	()
Division of Vital Re To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: 1	27. Manner of Daath 1 Naturai 5 Pending 2 Accidant investigation 3 Sulcida 6 Could not be	a. Date of Injury (Month, Day Year)	28b. Tima of Injury		Injury at Work? 1 ☐ Yas		-	8d. Dascribe he			<i>y</i>
Divi	Certifi	4 Homicida datarmined 28	 Piaca of Injury - At ho building, atc. (Spacify) 	ma, farm, stra)	at, factory, of	fica		2	8f. Location (Si City or Town	raat and Numb n, Stata)	er or Rura	l Routa Number,
Division To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Cartifier (Check only one) Certifying Phyaiclar 2 Medical Examiner:	To the best of my know on the besis of axaminet and manner statad.	vledge, deeth ion end/or inve	occurred et the estigation, in a	ne tima, my opini	dete end pl	ace, ar	nd dua to the co	euse(s) and ma ata and piace,	annar as st end due to	eted. tha cause(s)
To t To t	Σ	29b. Signature and titla of cartifiar			29c. Li	cansa ni	u <i>m</i> ber		2	9d. Dete signe	d (Month, i	Dey, Yeer)
		30. Name end addrass of person who compla	lad cause of death /Item	23a) /Type B		098	7			Dec.	10,	1999
		Ahmed Nawaz, 3				rido	ge, N	4D	21613			
Sta Registra		31. Dete filed (Month, Day, Year) DEC 1 3 199	32. Hegistrar's Signat	ure	i. Sp	out	1					



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State of Maryland / Department of Health and Mental Hygiene

Physician	Decedant's Name (First, Middla, Las			Certifica	te of		2. Data of De	Day	Yaar 3. Tima of Death		
/Medical Examiner	COLLEEN FAYE 4a Facility Nama (If not institution, give					4b. City, Town, or Lo		BER 10,	1999 7:48 AM of Death		
Lammer	Saint Joseph	Medical	Cente			Tows			Baltimore		
Funeral Director	5. Social Security Number 6. Security Number 11 217-28-9934 Usual Rasidence of Decedant	9X 7. Age ☐ M 253€F	(In yrs. lest bi	Yrs. If Und Month	er 1 Year S Days		8. Data of Bir (Month, De 1/1/	th ey, Year) 1932	9. Birthplace (State or Foreign Country) Maryland		
how	10a. Stata 10b. County		10c. City, Tow	n or Location					10d. inslda City Limits		
the Marylar 28a-f show notified at	Maryland Harfor	rd	St	reet					1 ☐ Yes 2](() No		
iffer death with the Me r Herne 23s or 28s-1 s in terms 15s or 28s-1 s in terms 15s or 28s-1 s	3731 Miller Roa				ip Code	21154			States		
all definition of the manufacture of the manufacture of other than "natural", or them 23s or 28s-f show event, for Medical Examinat must be nettined at event, for Medical Examinat must be nettined at Be Completed by Funeral Director	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forcas? 1 ☐ Yes 2 ② No If Yes, Giva Yaar or Datas:				Hispanic Origin? (Spoan, Mexican, Puarto Specify:	ecify Yas or No Rican, atc.)	Blac	e - Amaricen Indian, ck, Whita, atc. White		
-natu	15. Decedent's Edi (Specify only highast gred	ucetion da com <i>platad)</i>	16a	. Decedent's Us (Give kind of	uel Occu rork done	pation during most of work d)	ing	16b. Kind of B	usinass/Industry		
then then omp	Elamantary/Secondery (0-12)	Collega (1-4or 5+)	Clerk		10)		Pharm	acy		
d other than event, the	17. Father's Nema (First, Middla, Last)					18. Mother's Name	a (First, Middle	, Maiden Sumen	ie)		
Mente of To	Claude Yoder					Haze	1 Bead	chy			
is man	19a. informant's Name/Reletionship (7) Edward D. You					tend Number or Run 1er Road					
Health em 27	20a. Method of Disposition	iei – nus	20b. Placa	of Disposition (A	ama of		Data		City or Town, State		
permit. Fages a rand 2 knoting be permit. Department of Health and Mental Hygien important: If item 27 is marked other thy any injury or other traumatic event, the page. To Be Com	1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,)		ry Cen	ete	ry 1	2/13	Street			
Depa impo any ii	21. Signature of Funeral Service Licent	Jovela	ilse	Harki	ns				Delta, PA		
h!-!	shock, or heart failure. List only of	Meations that caused to one cause on each line	ha daath. Do	not enter tha m	ode of dy	ing, such as cardiac	or raspiratory a	rrast,	Approximata interval Batwean Onsat and Death		
nysician Medical	Immediata Causa (Final	LOW CA	RDIAC	OUTPU	T				1 HOUR		
xaminer	disaasa or condition rasulting in daath)	a Dua to (or as a consequence of):									
ir ir		POST O	12 HOUR								
physician and is the bunal-transit edical Examiner	Sequentially list conditions, if eny, laading to immadiata cause. Entar Undarlying Cause (Disease or injury	D									
the buri	trial militated events	c. COAGUL	12 HOUR								
5 0	rasulting in death) Last	d. CORONARY AND VALVULAR HEART DISEASE							22 YEAR		
the ath hed for	Part II. Other eignificant conditions co	ntributing to death but	not rasulting i	n tha underlying	causa gi	iven in Pert t.	23b. Did	tobacco uae co	ntribute to the cause of death		
detached							10	Yee 2 No	3 Probably 4 Unknow		
ate has been signed by the attending physicial, page 2 should be detached for use as the burn.								en autopsy ormed?	24b. Wara autopsy findings available prior to completion of causa of deeth?		
ntificata has stor, page 2 s							10	Yas 2 No	1 □ Yas 2 No		
certificata	25. Was casa refarred to medical examinar?					26. Place of Deat	h (Check only	ona)			
a la	TLI Fas ZINO		2 ER/O		WA			dence 6 Oth			
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rs after death. si Director: After this certification by the funeral director. Certification: To Be (3 Suicide 6 Could not be detarmined	28a. Placa of Injury building, atc.	arm, street, facto	28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)							
within 24 hours after death. To the Funeral Director: At completaly filled in by the fur Medical Certificatio	29a. Certifier (Check only one) Certifying Phy 2 Medicat Exami	etclan: To the best of iner: On the besis of and manner state	xamination an	e, deeth occurre nd/or invastigation	d et the ti	ime, date and plece, opinion, death occurr	end due to the red at tha tima,	ceuse(s) end me data and place,	enner es steted. and due to tha cause(s)		
Within To the comple	200. Signature and title of certifier/			2	9c. Licen	se number		29d. Data signa	d (Month, Day, Year)		
	· NoT 14	1/-			D 30	1446		12/	10/99		
12	30. Nama and address of person who co PETER HORNEFFE				DRI	VE, TOWS	SON, M	D 2120	4		
State	31. Data tiled (Month, Day, Year) DEC 1 4 190	32. Degistrar	's Signatura	,	,						



Adams, Koweng Ernest

State of Maryland / Department of Health and Mental Hygiene Q Q 40648 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death October 14 1999 **Physician** Rowena 2051 Ernestine Adams /Medical 4c. County of Deeth 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital ambridge Dorchester (seneral Dorchester 8. Data of Birth Sept. Day, Year 2 if Under 1 Yeer | If Under 24 Hrs. 9. Birthplaca (Stata or Foraign 7. Age (In yrs. last birthday) **Funeral** Days 213-16-8282 Months Hours Director Usual Residence of Decedant 72 hours eftar death with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Merylan Department of Hasilar and Mental Hygiene. Important: If team 27 is marked other than "naturel; or Itema 23a or 28a-f show any injury or other traumatic event, in Medical Examinat man be notified as 1 Was 2 □ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zlp Code 10g. Citizan of What Country? 520 Glenburn Avenue 21613 US Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes. ½ ᡚ No If Yas, Give Year or Detes: Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Bleck, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) College (1-4or 5+) line worker food processing 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Olie Robinson Arie Truitt 19a. informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Daphne Legg Daughter 5801 Green Point Road East New Market, MD 21631 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata MXBurlai 2 Cramation 3 Ramovel from Stata 4 Donation 5 Other (Specify) Dorchester Memorial Park 10/19/99 Cambridge, Maryland 21. Signature of Funarai Sarvice Licansee 22. Nama and Addrass of Facility Thomas Funeral Home, P.A. 700 Locust-Street Cambridge, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batwaan Onsat and Death Physician immediata Cause (Final, disaasa or condition rasulting in death) /Medical neumania Examiner Due to (or as a consequance of): Examiner ettending physician and for use as the burial-transit Sequentielly list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Due to (or as e censequance of): Textuction Records, P.O. Box 68760 Physician/Medical Dua to (or es e consequança of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ should b 24b. Wara autopsy findings available prior to complation of cause of daeth? Completed 24a. Was an autopsy The lew NIA page 2 : certificate has 1 ☐ Yas 2 ₽ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes casa referred to medical exeminar? Be 26. Pieca of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No Minpatient 2□ER/Outpatient 3□ DOA After this in by the funeral 28a. Data of injury (Month, Day Year) 28c. injury at Work? 27. Mannar of Death Certification: 28b. Tima of 28d. Dascribe how injury occurred To the Hospital or Attending I within 24 hours efter death.
To the Funeral Director: After MIA 5 Panding invastigation 1 Maturai fnjury NIM 1 Yas NA 2 Accident 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 Homicide edical **Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar complataly 29d. Date signed (Month, Day, Year) 29b. Signetura end titla of sortist 29c. Licansa number 0050799 30. Name and sddrass of person who complated causa of death (item 23e) (Type, Print) 302 Collin Ave. Hurlock, SHIRIN HOMAMMAP 3 31. Data filed (Month, Day, Year)

32. Registrer's Signatura

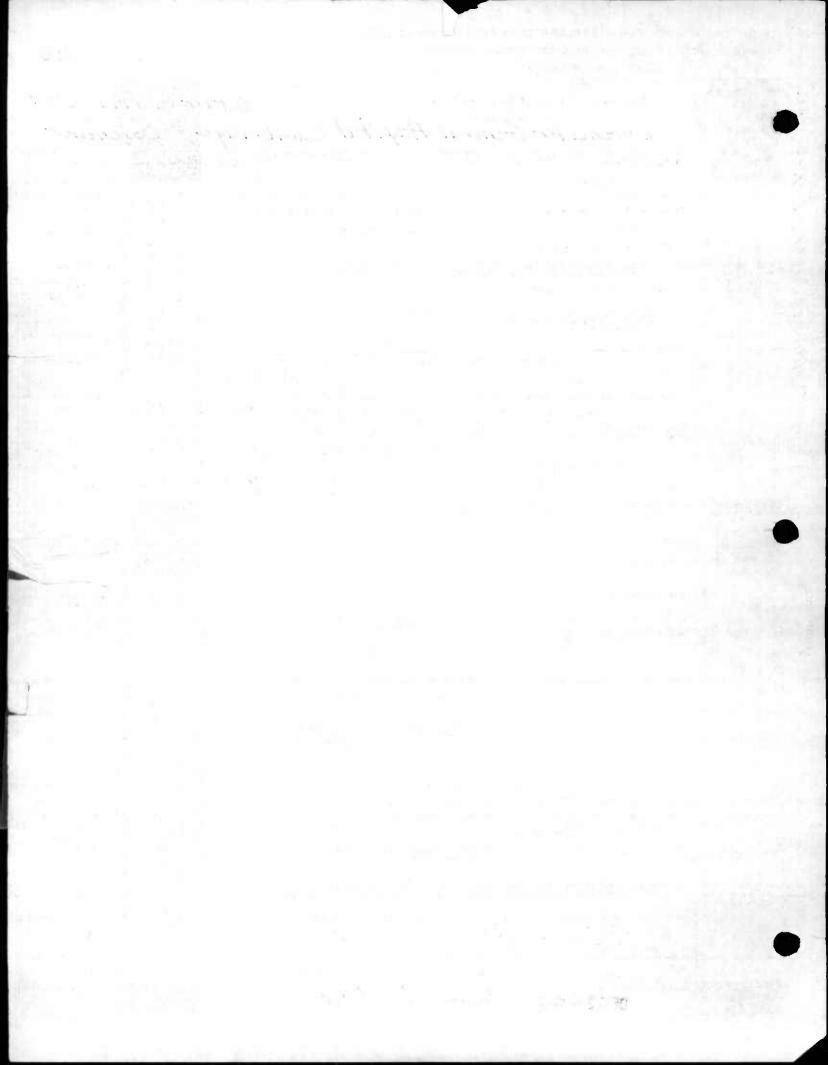
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State

Registrar



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State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** 1999 10:50 AM 10 Howard 2 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Long Green Center Genesis Elder Care Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Months Deys 1 M 2□ F Director 81 11-16-18 NC 238-24-7676A with the Maryland parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiane.
Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2□No MD NA Director Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 3317 Parklawn Drive 21213 USA Funeral 14. Reca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) XIXYes 2 □ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: b **X** Wldowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipyard Bethlehem Steel Co. 4th Grade NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Peter Allen Alice Lewis 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Fulton 3317 Parklawn Avenue Baltimore, Md. 21213 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date Marial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Denetion 5 ☐ Other (Specify) Crownsville VA Cem. 12-29-99 Crownsville,MD Funeral Service L 21. Signatur 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, each line. Approximete Intervel Between Onset and Deeth heart failure. List only **Physician** /Medical Immediate Cause (Finel M. wites diseese or condition resulting in death) Examiner Examiner nosde 10 hc law requires that the death certificate be axecuted physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Diabeles llita Division of Vital Records, P.O. Box 68760, Mc Physician/Medical Due to (or as e consequenca of) signed by the a ld be datached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evaitable prior to Completed 24a. Wes en autopsy performed? peed completion of cause of deeth? has The 1 ☐ Yes 2 ☐ No certificata 1 Yes 2 No Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No mis funara 27. Menner of Deeth 28b. Time of 28e. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28c. Injury et Work? Certification: After or Attending 1 Naturel 5 Pending investigation A Funeral Director: A Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) To the To the T 29th Signature and time op-29d. Dete signed (Month, Dey, Year) Adensina Dec 22/ 30. Name and accress of person who completed cause of deeth (Item 23a) (Type, Print) Schwartz MD 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State DEC 2 9 1999 Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Yee **Physician** 4.33 am JOHN HARMAN ADAMS 26 1999 /Medical becember 4e Facility Nema (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Franklin Square Hospital center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | July 18 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months 1X M 2 F 413-26-2021 Director Tenn. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD 1□Yes 2□No Baltimore Middle River Director naturel, or fisms 23s or 25s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Honeycomb Road 21220 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Black, White, etc. 1X Yas 2 No If Yas, Give Year or Datas: 1 Never Merried 2 Merried 1 Yes 2 XNo Specify: Specify: White þ 3☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4th Laborer American Standard pegg permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event, pages. Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be unknown unknown 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Seganish / Guardian 606 Baltimore Ave. Towson Md. 21204 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Gardens of Faith 12/30/99 Rossville MD. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex oun Mace Ave. Baltimore Md . Approximate 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart tailure. List only one cadse on each line. Intarvel Between Onset and Death Physician Immediate Causa (Final diseasa or condition resulting in death) /Medical · Preumonia Incer Weeks Examiner Due to (or es e consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): 68760 Due to (or as a consequence of) Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by should t 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? is certificate h 2000 1 ☐ Yes 2 ☐ No 1 Yes Division of Vitai Attending Physician: Be 25. Was casa refarred to medical examiner? 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mariner of Death 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending investigation death, 1 Yes 2 No To the Hospital or Attendivithin 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicida edicai 1 Lectifying Physician: To the best of my knowledge, death occurred et the tima, data and place, end due to the cause(s) end menner es stated. 29a, Cartifie 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

6

DHMH 16 Rev 6/95

John

DAMS

State Registrar

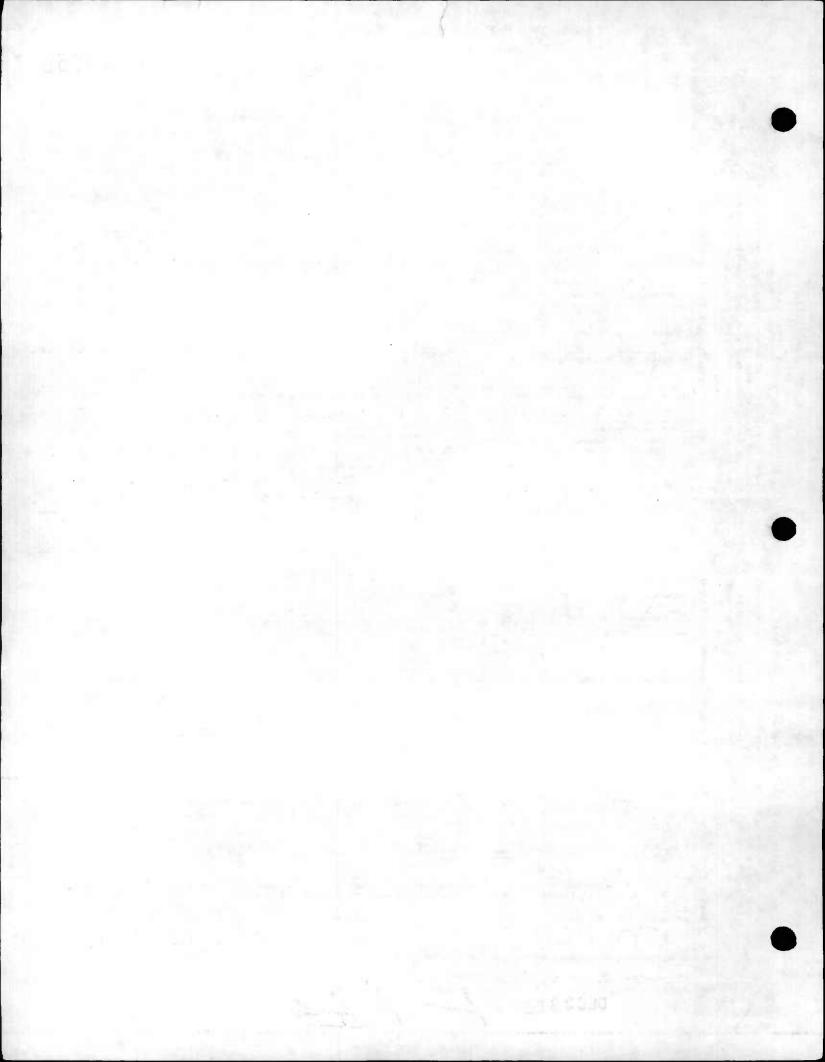
DR Ma Dai CHar Don

31. Data filed (Month, Day, Year) 32. Registrarts Signature DEC 29

30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print)

9000 Frankin square Drive pattimore maryland

RD 192658

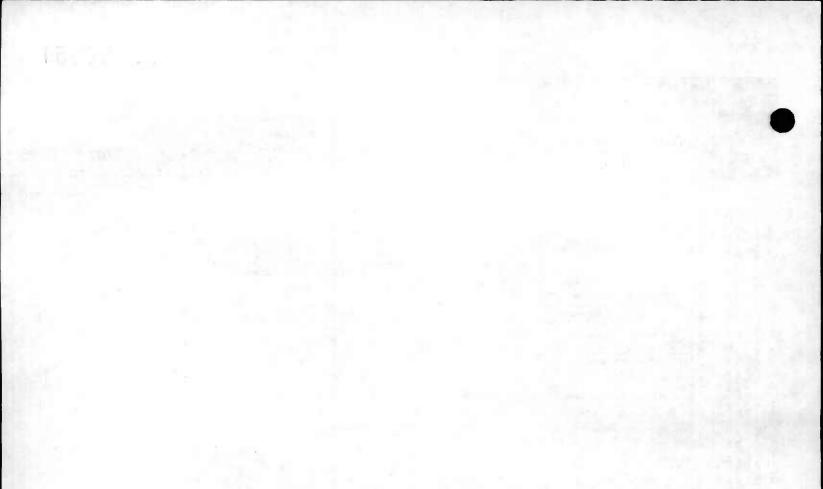


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

40651 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Bryan Donald December 28, 2:19 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NorThwind Ferquson aITU aT If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) May 3, 1977 9. Birthplaca (Stete or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□F 212-08-0502 22 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ (No Baltimore Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 2 ma 23a 14 Windsor Way 21237 U.S.A. e filed within 72 hours after deeth all Hygiene.
other than "natural", or itema 23 vent, the Medical Example mana Funeral 14. Race - American indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) 12th Grade College (1-4or 5+) Construction Worker Construction Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy important: If flem 27 is marked other any fluing or other traumatic event plats. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Donald Bruce Aull Mary Kathleen Walker 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Lisa Aull (wife) 14 Windsor Way, Baltimore, MD 21237 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 1/3/00 Baltimore, Maryland 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD Approximete interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical hammat mulles TC Examiner Due to (or es a consequence of) Attending Physician: The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Records, should be d þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an sutopsy performed? certificate 1 ☐ Yes 2 ☐ No of Vital funeral director, Be 25. Wes case referred to medical 26. Placa of Deeth (Check only one) examiner r 1 Yes 2 No Hospitel: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ROAD WAY Certification: To this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending 1 ☐ Yes 2 M No Passenger in automobile within 24 hours after deeth. To the Funeral Director: A DEC 28,1999 investigation 0219 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) à 4 Homicide ò filled in BALTO RD at Fenguson Rd NORTHWIND Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

My

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 21237 completely (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7632 20 Han 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) J. CROSSAN BALTU DUNDALK AVE (LM mD NAVONORO 2112 21222 31. Date filed (Month, Dev. Yeer)
DEC 2 9 32. Régistrar's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				C	ertifica	te of	Death	Re	g. No. 9 5	1 4	0652
	1. Decedent's Nama (First, Middle, I	Lest)						2. Dete of Deet Month	h	Yeer	3. Time of Death
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Examiner	4a Fecility Name (If not institution, g	nive street and number	er)				4b. City, Town, or L		4c. County		
		15210 Bushy F	Park Roa	ad				Voodbine			oward
Funeral Director	5. Social Security Number 6. 214-74-8652 Usual Residence of Decedent	. Sex 7	Age (In yrs.	98 Yrs	Months	ler 1 Year s Days		8. Date of Birth (Month, Day, Novembe		9. Birthpi Coun	lace (State or Foreig try) Maryland
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vith the Me t or 28e-f s be notified Director	Maryland 10e. Street and Number	Howard			10f Z	ip Code	Woodbine	11	0g. Citizen of	What Coun	/ \
ath with matthe	15210 Bushy Park						21797				S.A.
Maryland 21215-0020 Astrological States of the states of	3 Widowed 4 □ Divorced	12. Wes Decede Armed Force 1 Yes 25 If Yes, Give Yeer or Dete	No No	,3.		2 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	o Rican, etc.)		ck, White,	
State State of State	15. Decedent's (Specify only highest of	Education grade completed)		(G	ecedent's Us	vork done	during most of won	king	16b. Kind of B	usinass/Inc	dustry
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Baltimore, Mary semit. Pages 1 and 2 sho separiment of Health and A separim	20a. Method of Disposition 1 Buriat 2 Cremetion 3	☐Removet from Sta	20b. F	cematery,	sposition (Normalized Normalized	leme of r other ple	эсе)		20c. Location	- City or To	wn, State
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	resulting in death) Last	d	Due to (d	or es e con	sequence of	1):					
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68	30. Nama and address of person who	o completed cause of	of death (Iter	m 23e) (Ty	pe. Print) V178	4	To the				
State	31. Date filed (Month, Dey, Year)	12. Regi	istrer's Signa	ature	4	1	1.				

DHMH 16 Rev 6/95 ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth December 23, 1999 Physician Manfred, Alle 10:00AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins - Bayview Baltimore 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) **Funeral** Deys Hours 70 Yrs. 216-32-242 Director Estonia 2/26/29 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Merylan Department of Health and Mentel Hygione.
Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show highry or other treumatic event, the Medical Examinar must be notified at page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD N/A Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 508 South Macon Street 21224 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 14. Reca - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Merchant Marine Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aleksander Alle Sofia Maetamm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mr. Johan Alle / Brother 35 Ormskirk Aveune - Apt. 516, Toronto, Candada M6S1A8 20a. Method of Disposition

1 DBurial 2 DCremetion 3 Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete York Cemetery 01/04/00 Toronto, Canada 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Leonard J. Ruck, Inc. Tuneral Service Licensee Christina L. David 5305 Harford Road, Baltimore, Maryland 21214 Approximete Intarval Batween Onset and Death 23a. Pert1. Enter the disease, or complications that caused the d shock, or heart tailure. List only one cause on each line. eth. Do not enter the mode of dying, such as cardiec or respiretory errest, **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ettending physician and for use as the buriel-tran Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, temia Physician/Medical Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wera eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? pege 2 1 ☐ Yes 20 No certificete 1 Yes Division of Vital if or Attending Physician: efter death. 25. Was case referred to medicat axaminer? 8 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To AOD DE 1 Inpatient 2 ER/Outpatient this After thi funeral 27. Manner of Peath 1 A Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2□ Accident Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Directompletely filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.

Wedical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of contilled 29d. Date signed (Month, Dey, Year) 28

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DHMH 16 Rev 6/95

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State

Registrar

Eastern

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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DEC 2 9 1999

31. Date filed (Month, Day, Year)

3509

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 40654

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nerai	5	6. Social Security Number 6. 217-16-7449	Sex 7. Age	a (In yrs. last	birthday)	If Under Months	Year Days	# Under Hours	24 Hrs. Min.	8. Date of Birtl	year		9. Birthpli Count	
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Examiner count be notified by Funeral Director		Maritel Status Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 273N If Yes, Give			Vas Decede I Yes, speci I □ Yes 2	_	spanic Orle n, Mexicen Specify:	gin? (Spe , Puerto	cify Yes or No- Ricen, etc.)			e - America ck, White, e	
1 44	-	3 ☑ Widowad 4 □ Divorced	Year or Dates:										WHI	
	L	15. Decedent's E (Specify only highest g	ducetion ade completed)	10	6a. Deced	lent's Usual kind of work DO NOT use	Occupa done	ation fu <i>nng m</i> ost	of worki	ng	16b. F	Cind of Bu	usiness/Indu	ustry
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		PETER LINDSAY								ARVEY			,	
traumatic • To E		9e. Informant's Name/Relationship	(Type, Print)	1	9b. Mailin	g Address	(Street a			I Route Numbe	r. City	or Town.	State. Zip (Code)
4 .	F	ROBERT W. LIND	SAY (BROTH							WSON, M				
	2	0a. Method of Disposition		20b. Piace	of Dispo	sition (Nam	e of			Date			City or Tow	vn, Stete
ILY OF		1 Denation 2 □ Cremation 3 [4 □ Donation 5 □ Other (Special		1		D PA		0)	12	/23/99	P	ARKV	TT.T.F	. MD
any injury or once.	2	1. Signature of Funeral Service Lice	nsee			. Name and		s of Facility		23,39	1 1	TIVIL V	TUUL	, MD.
any l		William (Par = Till		H					S & SO				
	1	23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused t	the death. D						ALTO.,		• 21		Approximate
cian	1	snock, or near failure. List only	one cause on each line	ሽ										intarval Betwaa Onset and Deat
dical	li	mmediate Cause (Final lisease or condition	N Rails	NEUV	MON	IA							1	lick
niner	r	esuiting in death)	0.	Due to (or as	-									
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the bunal-transit	S	sequentially list conditions, any, laading to immadiate ause. Enter Underlying ause (Olseese or Injury	D	Due to (or as	a consequ	uence of):								
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ZWe	re	art II. Other significant conditions	d		g in tha un	derlying cer	use give	on in Part i.		23b. Did to		use cor		
ZWe	re	esulting In death) Lest	d		g in tha un	derlying cer	use give	en in Part i.		1 🗆 Y	08 2	No.	3 Probe	ably 4 Unk
hould be datached for use eseted by Physician/Me	re	art II. Other significant conditions	d		g in tha un	derlying cer	use give	on in Part i.			es 2	No.	3 Probe	e sutopsy tindin labia prior to pletion of ceuse
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TOTAL ON STREET TO COMMENT OF STREET

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dev Year **Physician** DECEMBER 25, 1999 10:20 A.M /Medical FRANK CAMINITI 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MANOR CARE TOWSON TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours XXM 2□ F Yrs 215-09-9460 102 Director 8/29/1897 ITALY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 PROVIDENCE ROAD Funeral USA 14. Race - Americen Indien, Black, White, etc. 21286 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 22 No
If Yes, Give
Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried Merried 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hyglana. Elementery/Secondary (0-12) College (1-4or 5+) 5th GRADE TAILOR GRUE TAILORING other Baltimore, Maryland permit. Pegas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event, page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ANTONINO CAMINITI CONCETTA TRIMARCHI 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) NANCY CAMINITI WIFE TOWSON, 824 PROVIDENCE ROAD MD 21286 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burial ✓ Cremetion 3 Removel from Stete 5 ☐ Other (Specify) 4 Donetie MOST HOLY REDEEMER CEM. 12/28/99 BALTIMORE, MD 22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A. Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 hat curred the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, on each line. Approximete tntervet Between Onset and Death 23a Part . Enter the disease, or complicet shock, or heart feiture. List only one **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner attanding physician and for usa as the burial-tren Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760 **Physiclan/Medical** Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown 20 re or The law requires that Records, Š 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 Yes 2 TNo cartificata Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartificately filled in by the funeral director. 25. Wes cese referred to fiedical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2010 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Medical To the Hospi within 24 hou To the Funer complately fil 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner steted. 29b. Signeture end title of certifies 29c. License number 29d. Date signed (Month, Day, Year) M CTKR HARFORD ess of person who completed ceuse of deeth (Item 23a) (Type, Print) 8993 Dr40 0 TIMORE 31. Dete tiled (Month 32. Registrer's Signeture State 2/234 Registrar

AH

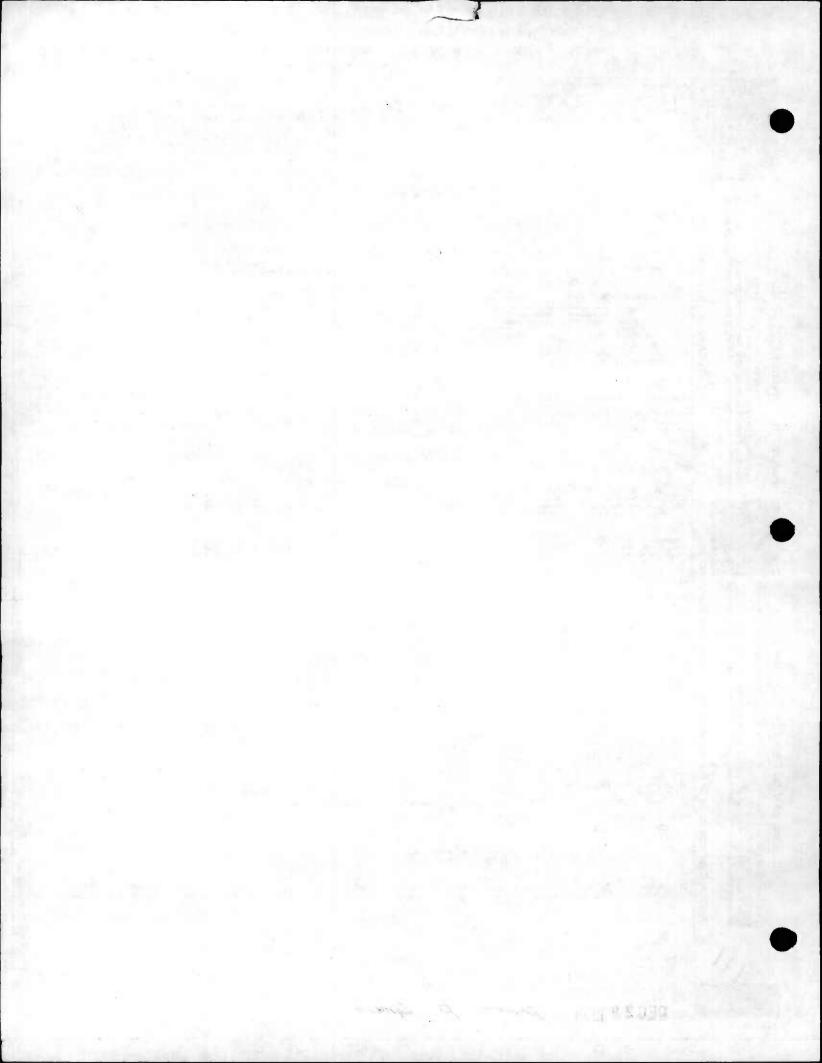
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 40656 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Yeer Month **Physician** REGINALD BRIDGES December P5 1999 0700 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NURSING HOME BALTIMORE HARBORSIDE If Under 1 Yeer | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 MM 2□ F Yrs. 220-20-4103 Director MARCH 19,1928 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yas 2 No BALTIMORE Directo MARYLAND NA 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4700 ().S.A. HARFORD ROAD Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yas, Give Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or han eny injury or other treumatic event, tre Medical Farm and 1 Never Married 2 ☐ Married 21215-0020 1 Yas 2 No Specify: 2 Specify: BLACK 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE STEEL BETHLEHEM STEEL WORKER Baitimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) B (MN-UNKNOWS) BERTHA BENNIE BRIDGES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) NORTHBEND ROAD, APT. DA, BALTO, MD 21229 HNGEL ANDREWS (NIECE) 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from Stata METRO CREMATORY 12-29-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility JOSEPH H. BROWN JR. FUNERAL HOME 21217 Q140 N. FULTON AVENUE, BALTIMORE, MD Approximete Interval Batween Onsat and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Acute myocardial infarction minutes diseasa or condition rasulting in death) Examiner Dua to (or as a consequenca of) Physician/Medical Examiner Corona The law requires that the death certificate be executed attending physician and for use as the burlai-tran Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown diabets be dat ğ Completed 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? has this certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certifical eleity filled in by the funeral director, 25. Was casa refarred to medical examiner? Be 26. Placa of Daath (Check only ona) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Watural 1 Yas 2 No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 737573 28,1999 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) MD Ave Baltime MP ZIZOK 3015 Park Heyhts 7220 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

DEC 2 9 1999



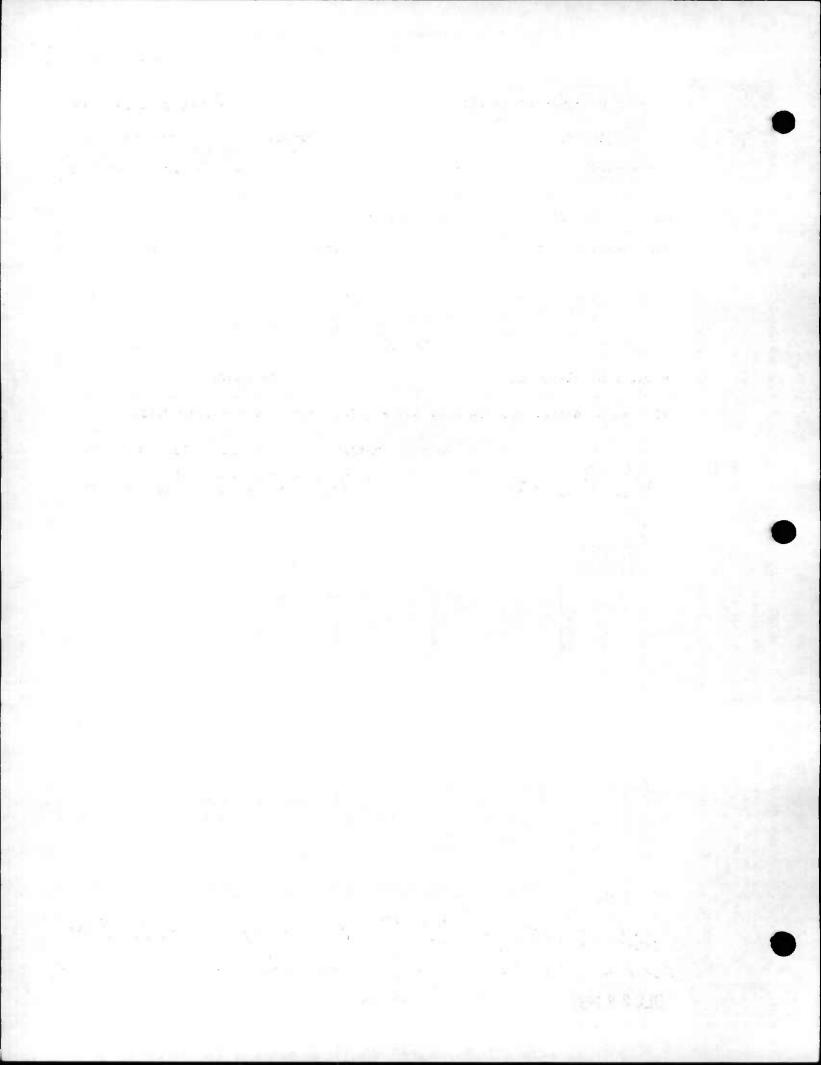
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** William Benjamin Blair III December 26 1999 0843 /Medical 4e. Feclity Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 547 Higgins Drive Odenton Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Sociei Security Number 8. Dete of Birth (Month, Dey, Year) May 23, 19 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) Funeral Deys 1□XM 2□ F Hours 219-76-9049 39 Yes Director 1960 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at Director 1 ☐ Yas 2 X No MD Carroll Manchester or 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3404 Manchester Pike Нете 23а 21102 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puarto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours efter 1 ☐ Yes 2♥ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 € No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumetic event, the Media 0008. Elementery/Secondery (0-12) College (1-4or 5+) 12 Railroad Engineer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be William B. Blair, Jr. Iris Giove 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William B. Blair, Jr. (Father) 547 Higgins Drive, Odenton, MD 21113 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory 12/29 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only price cause on each line. Approximete Intarvel Between Onset end Death **Physician** tmmediete Cause (Finel diseese or condition resulting in deeth) /Medical Malignancy, Brain unk Examiner Due to (or es e consequence of): The law requires that the death certificata be executed Physician/Medical Exam attending physician and for use as the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or Injury thet initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or es e consequenca of): P.0. Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown signed b Records, þ been sig 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Be Completed 24e. Wes an eutopsy performed? page 2 XIXNo certificate 1 TYes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. director, 25. Wes casa raferred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence & Wother (Specify) Residence Yes 2□ No 2 1 Inpatient 2 ER/Outpetient 3 DOA this funerai 28c. Injury at Work? 27. Mennar of Death 28e. Dete of tnjury (Month, Dey Year) Certification: 28b. Time of 28d. Dascribe how injury occurred After 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accidant eral Director: / filled in by tha f 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours To the Hosp within 24 hou To the Funer completely fil 29e. Certifler 1 Certifying Physician: To the best of my knowledga, deeth occurred et the tima, date end place, and dua to the cause(s) end mannar as steted. Medical **Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Dey, Year) 29b. Signetura end titla of certifier Deputy 29c, License number D 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 695 America Ct. 21035 JONES, MO William

State Registrar

31. Deta filed (Month, Dey, Year)

DEC 2 9 1999

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

ian		me (First, Middle, Las							2. Data of D Month		Year	3. Time of Death
		Felix Bel									1999	8:45 pm
r		(If not institution, give		or)					ocation of Dea	th 4c. Cour	nty of Death	
	1052 Be 5. Social Security	enning Road	-	Ana (In vrs	last birthday)	If Under 1 Yea		SVil			Arun	
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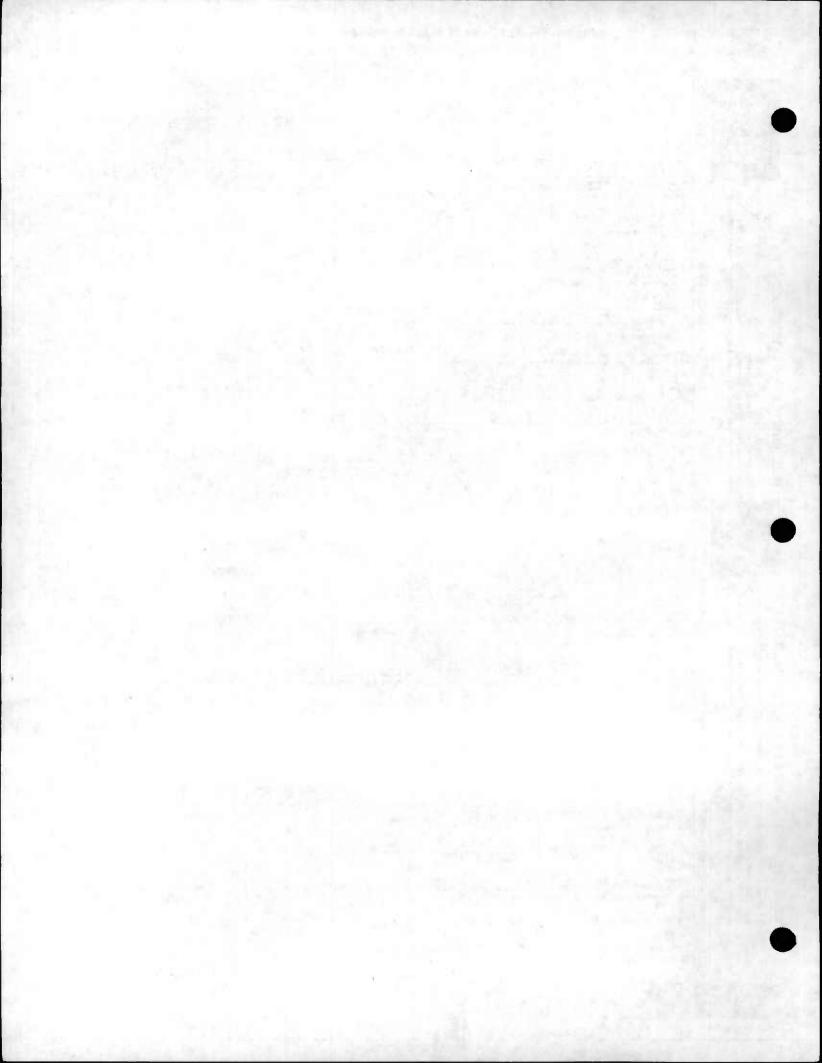
State Registrar

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32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year 90 **Physician** MARY BANA SKIE WICZ DECEMBER 21,1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) April 9, 1923 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2ØF 76 Yrs. 216-18-4670 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maruland 1 Yes 2 No Baltimore. Baltimore Director 10a. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 15 Cliffwood Road 21206 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If Item 27 is marked other than 1 say injury or other thaumatic event, the Mes Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Owner and Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William L. Iardella Maud Cronwell 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. June Nemec (daughter) 4222 Mispillion Road, Baltimore, MD 21236 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 Cremation 3 Removal from Stata cemetery, cremetery or other place)
4 Donation 5 XOther (Specify) Entombment Moreland Mem'l Park Maus. 12/27/99 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Buan a. Weller 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Introcerebral bleeding Examiner Due to (or es a consequence of): Brain humor Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. piration Physician/Medical Due to (or as e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown ten sion Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yas 20 No 1 ☐ Yes 2 ☑ No of Vital or Attending Physician; 8 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2⊠ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Affert 164Naturat 5 Pending investigation To the Hospital or Attending within 24 hours after death.

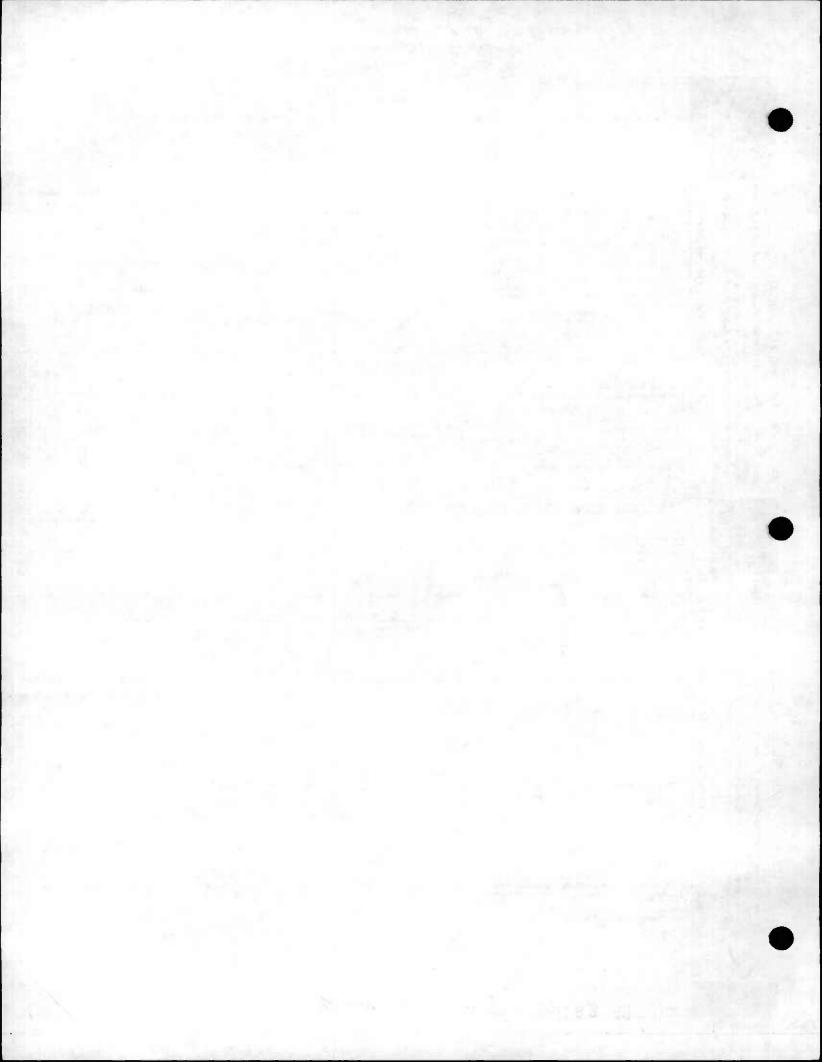
To the Funeral Director: After completely filled in by the funeral completely f 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) P 11390 December 21, 1999 1 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) BALTIMOLS, ND 21239 BLUD NONA SAB RA SGOI LOCH RAVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DHMH 16 Rev 6/95

DEC 2 9 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** Tillman 3:40 PM DOYX December /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita 6. sok more + Baltmore 0 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 246-14-4380 Days 101 20 F Yrs. Jan. **Director** 6 Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at BALTIMORE 1 485 2 No NA Director WP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dolfield the AZU 21215 3341 12. Was Dacedant Evar in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: specify: Black à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working lifa. DO NOT use retired) Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 39er TH NA permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, the 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be 200 10 Magno lia 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number of Pural Route Number, City or Town, State, Zip Code) Ave. Md 3333 Dolfie DRENda Ito. 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Arbutus Memorialte 4 ☐ Donation 5 ☐ Othar (Specify) 12.29-99 21. Signature of Funaral Sarvica Licansaa 22. Nama and Address of Facility Hone West, From uneral arch Harrie 4300 Wabash Md Aug 23a. Parl 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** myocardial Infarction Immediata Causa (Final disaasa or condition rasulting in daath) /Medical **Examiner** Physician/Medical Examiner apter 4 CORUNARY burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury Dua to (or as a consequenca of) that initiated avants rasulting in death) Last Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown ate has been signed page 2 should be det Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 2 No 1 Yas 1 ☐ Yas 2 No Division of Vital Attending Physician: 25. Was casa rafarrad to medical 26. Placa of Death (Check only one) axaminar? 1X Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Medical Certification: To 1 Inpatient 2 R/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Invastigation f Natural death. 1 Yas 2 No 2 Accident rector: 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) To the Hospital or Att within 24 hours atter of To the Funeral Direct completely filled in by 4 Homicida To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier 29d. Data signad (Month, Day, Year) 29b. Signatura and title of certifiar 29c. Licansa number

State Registrar

DHMH 16 Rev 6/95

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30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

DEC 2 9 1999

DAMES

32. Registrar's Signatura

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31. Data filed (Month, Day, Year)

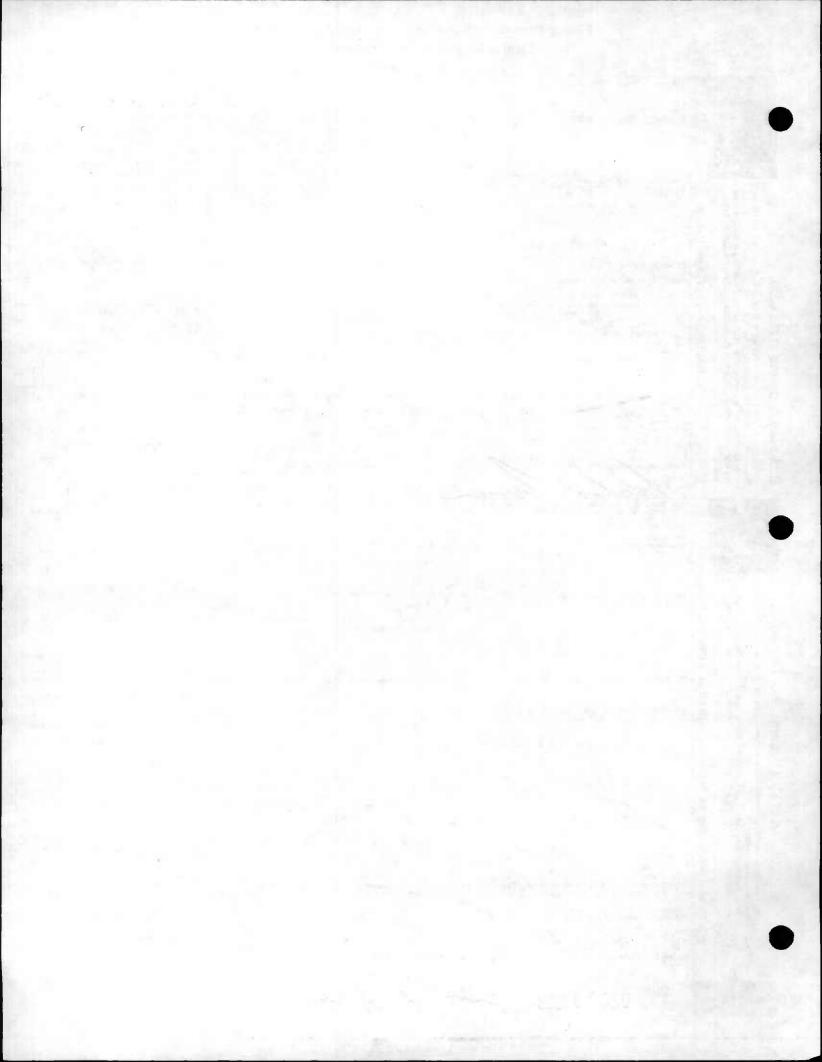
December 24,1999 BAHO: MD 21215

SINAI HOSPITA

2401 W. Belvedere

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Michael A. Bavota December 22. 1999 9:20 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 10, 1910 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 F Yrs 216-32-7017 Director 89 Maryland Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 No Director or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 811 Stamford Road 230 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 natural, or White 1 ☐ Yes 2 ☑ No Specify: à Specify 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Barber Shop Barber permit. Pages 1 and 2 should be fire Department of Health and Mental Hy Important: If Nem 27 is marked othy any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Umberto Bavota CHIARINA GENTILE 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 Candlelight Cove Drive, Sykesville, MD 21784 Inez Patricia Keeper (Daughter) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Crestlawn Memorial Garden12/27/99 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 mm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cances ostate Examiner Due to (or as a consequence of): Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the bunal-tran Due to (or as a consequence ot): P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by 1 Yes 2 No 3 Probably 4 Miknown Division of Vitai Records. þ should be d Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 certificate 1 Yes 200 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred t Natural 2 Accident 5 Pending investigation death. 1 Tyes 2 □ No 24 hours after deat Funeral Director: 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 more Miller 99 2 D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kannord Miller Street Main Reisteshows MI 25 Sute 31. Date filed (Month, Day, Year)
DEC 2 9 1999 32. Registrar's Signature State Registrar

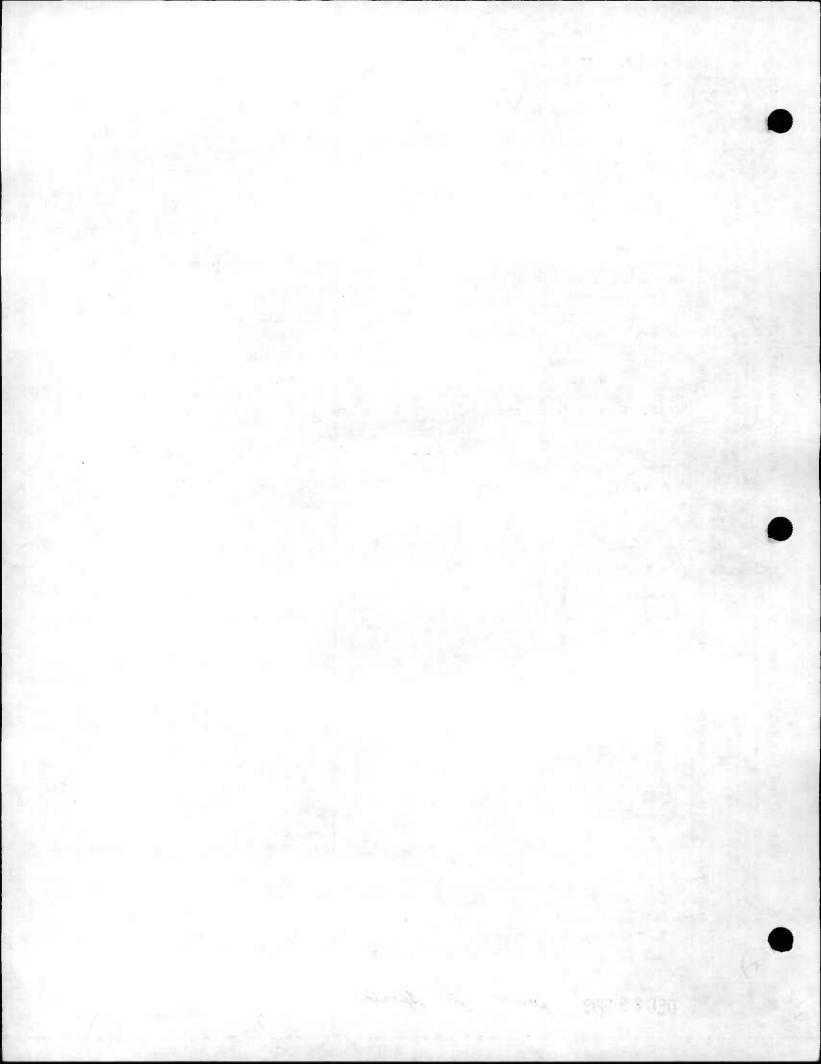


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State of Maryland / Department of Health and Mental Hygiene 40663 AMEND#20b PER F.H. G779 1-3-2000 J.A. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death
Month
Day
PECEMBER 25, 1999
coation of Death
4c. County of Death **Physician** BENNETT 05EpH 20:10 /Medical 4a Facility Name of not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 405 AltiMORE City N/ 8. Date of Bigh (Month, Day, Year) If Under 1 Year | Months Days If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country)
 Md 7. Aga (In yrs. last birthday) 6. Sex **Funeral** Days Hours 10 M 20 F Yrs. 54 216-42-8038 Director 08 02 Usual Residenca of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 1 ☐ Yes 2 ☐ No Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 3310 Leverton Avenue 21224 IISA Funeral 'natural', or Nems 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14. Raca - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notit Yes, specify Cuban, Mexican, Puerto Rican, atc.) filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed ADDivorced white Year or Dates: Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unemployed N/ permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: if Item 27 is marked othe any Injury or other traumatic event DOSs. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Joseph Bennett Dorothy Lingerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Cardona/daughter 6110 Shipview Way, Balto, Md. 21224 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/29/99 Baltimore-Washington Laurel, Md 21. Signature of Funeral Sarvice License 22. Name and Address of Facility Moran-Ashton-Dabrowski Funeral Home, Inc 02 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SUAUMOUS CELL CARCINOMA, LUNG Examiner Due to (or as a consequence of): Physician/Medicai Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician end for use as the bunal-tran Due to (or as a consequence of): Box 68760. Dua to (or as a consequenca of) P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 1 No 2 No 3 Probably 4 Unknown Division of Vital Records. þ page 2 should b 24b. Were autopsy tindings availabla prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? is certificate h 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical elashy filled in by the funeral director. 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 (Inpatient Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiar (Check only one) it Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated. Medical completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. To the Within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) INTERN SALOMEH MAHI 19ES-000 DECEMBER 25 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 N CAROLINE STREET BAITIMURE MD KEYHANI DALOMEH 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State DEC 2 9 1999

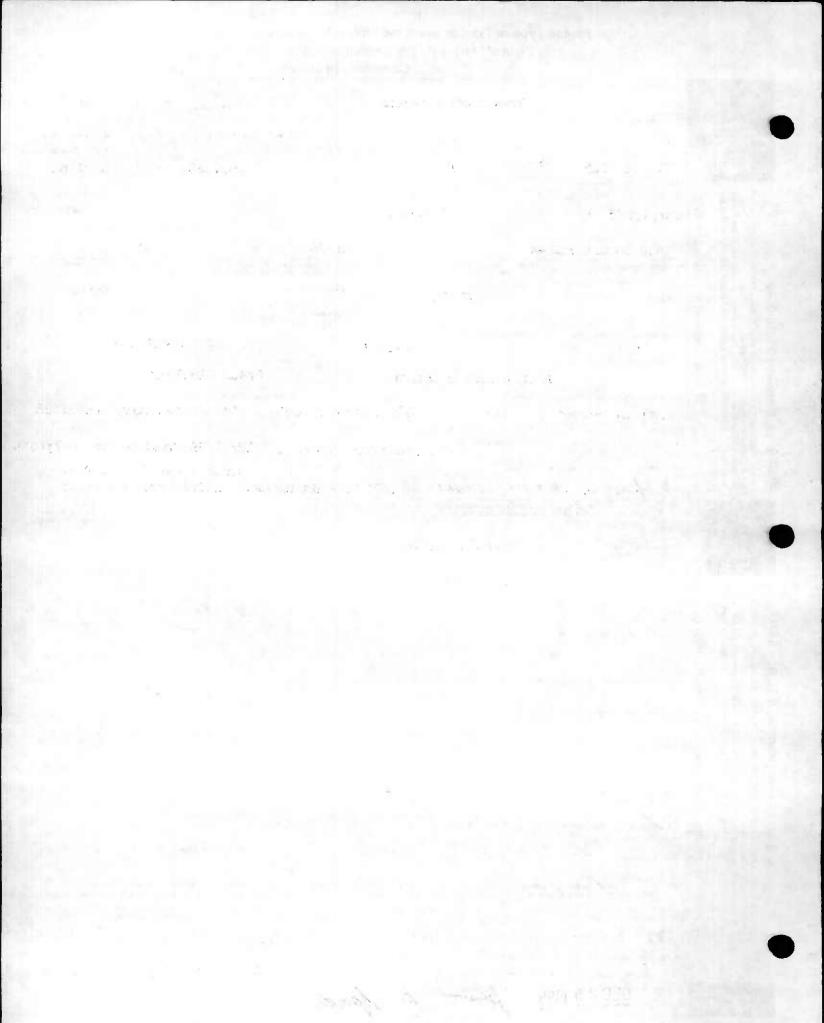
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Registrar



Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 4065

				Ce	rtificate	e of	Death			Reg. No.		41111	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Estelle Farren Boles 4a Facility Name (If not institution, give street and number) 4b. City, Town, or								2. Date of De Month	ber 23	Year 1999	3. Time of Deat 5:55 PM	
Examiner	St. Agnos H	tospifel		Baltono) N/A	. A		
Funeral Director	5. Social Security Number 218-26-2250	6. Sex 1 M 2 XF	7. Age (In yrs. 67	last birthday) Yrs.	Months		Hours	24 Hrs. Min.	8. Date of Bir (Month, De Feb.]	th by, Year) L, 1932	9. Birthp Coun Mary	lace (Stete or For fry) 'Iand	
2 >	Usual Residence of Decedent 10a. State 10b. Coun		1400 CH	ty, Town or Lo								0d. Inside City Lir	
or 28a-f show be notified at Director	Maryland E	Baltimore	100. 01	ty, rown or Ec			ridge					1 ☐ Yes 2√	
23a or 2 unt be n	10e. Street and Number 6013 Augustir		10f. Zip Code 21227					10g. Citizen of What Co			•		
natural; or items 23s or 28s-f show dical Examiner must be notified at eted by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mi 3 ☑ Widowed 4 □ Divorce	Armed 1 Ye	ecedent Ever in U Forces? s 2 🖾 No Give r Detes:				Hispanic Origin? (Specify Yes or Niban, Mexican, Puerto Rican, etc.) Specify:		ecify Yes or No Rican, etc.)	Specify:			
# ÷	15. Decede (Specify only high Elementary/Secondary (0-12	ent's Education lest grade complete	d) a (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			t of worki	ng	16b. Kind ot B				
Hygiane. Wher than am, the Me	9 Years	Oonege	(1-401 54)	Seli	Empl	loye	d			Reta		il	
Be every	17. Father's Name (First, Middle Joseph Farre				18. Mother's Name (First,						ne)		
and M la mari	19e. Informent's Name/Relatio	nship (Type Print)		19h Meili	na Address	(Street	end Numbe	er or Bure	I Route Numb	er, City or Town,	State Zio	Code)	
if Health and Mer fem 27 is marke other treumatic	Mr. Kent Bole				st.	Pau			Baltin	nore, Ma	rylan	d 2120	
rtant or	1 Burial 2 Cremation 4 Donation 5 Other	(Specify)	m State	cemetery, cre Litop s	matory or o	ther place ce_C	orp.	12/2	Date 7/1999	20c. Location		ryland	
Depa Impo	NU-	1. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Behavior, or heart failure. List only one cause on each line. 23. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Behavior Consett and Decorption of the Consett and											
hysician /Medical	Immediate Cause (Final		0.				ng, such as	cardiac o	r respiratory a	rrest, ²	1	Approximate Interval Between Onset end Deet	
xaminer	disease or condition resulting in death)	a	Vulmena. Due to (c	en rus	quence of):	om b	u s				1	Mesk	
nding physician and use as the bunal-trensit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		or as a consecutive as a consecutive									
been signed by the attending should be detached for use as leted by Physician/Me	Part II. Other significant condit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the c			
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w or O									24a. Was perto	an autopsy ormed?	24b. We ave con of c	ere autopsy findin elieble prior to inpletion of cause death?	
page page									1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ 1			Yes 20 No	
s cartificata director, pag To Be Co	25. Was case referred to medic examiner?	-						ot Death	(Check only	one)			
90	1 ☐ Yes 2 Ø No			ER/Outpaties			4 LI NU			idence 6 DOtt)	
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al Direct ed in by	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)								28f. Location (City or To	Street end Numi wn, State)	ber or Rure	l Route Number,	
he Funeral plataly filled edical Ce	29e. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the Examiner: On the and ma	he best of my kno basis of examina anner stated.	wledge, death ition and/or in	n occurred a vestigation,	at the tir	ne, date en pinion, dee	d plece, e	end due to the ed et the time,	cause(s) and m date end plece,	anner as st and due to	ated. the cause(s)	
within 2 To the compla	29b. Signature and title of certif	ier	0		290	. Licens	e number	,		29d. Date signe	d (Month,	Day, Year)	
~	Elmos	C/m.	Sh. 1	Gr	F	2/3	3594	1		Decemb	er 2	3 199	
30	30. Name and address of person Tom Balsh:	St. 40	use of death (Item	1 23a) (Type,	Print)	Bar	Hanor		MI)	21229)		
State Registrar	DEC 28 19	99 5	Registrar's Signa	iturgy	door	Kil							

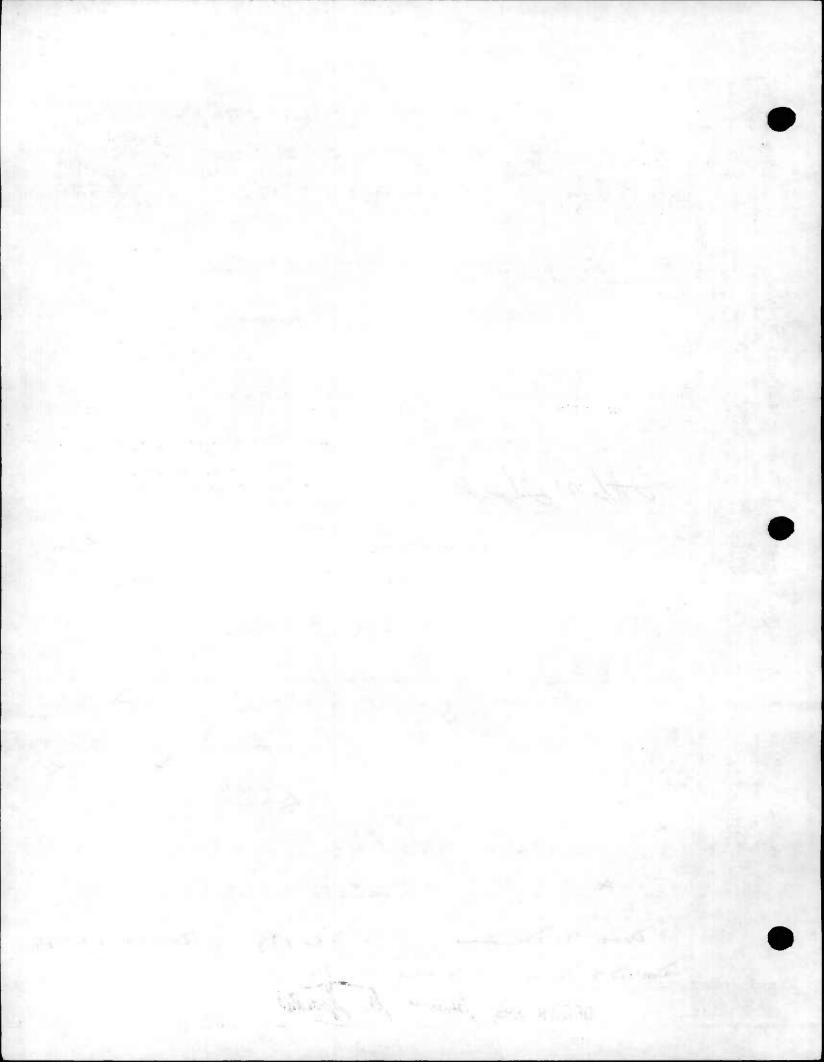
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State of Maryland / Department of Health and Mental Hygiene 99 40666

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/Medical Examiner	4a Facility Nama (If not institution, g			4b. City, To				of Death	0.17 F.F.					
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Funeral	5. Sociel Security Number 6	Sex 7. Ag	e (In yrs. last bir		r 1 Yaar	If Under	24 Hrs.	B. Data of Birth (Month, Day, 9/15/1	Veer		leca (Steta or Foraig			
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or or	MD N/A		Balti							10d. Inside City Limits 1 □Xyas 2 □ No				
28a-	10e. Street and Number		101. Zip Code					1/						
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Ter Ter	11. Marital Status	12. Was Decedent Evar in U,S. 13. Was I			dent of H	lispanic Orl	Igin? (Spec	ify Yas or No- ican, atc.)	14. Race - Amaricen India Black, Whita, atc.					
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Department of Health and wenter hygiene. Important: if item 27 is marked other than my Injury or other traumstic event, the Medica. To Be Compl	John Boeren/Son													
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Department of important: If it is any injury or o	21. Signature of Fungral Service Lic													
e i e	22. Nama and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21.													
	VIVO "I FASKA"													
ysician	23a. Part1. Enter the defease or completion of at each ed the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or have failure. List only one cause on each line. Approximate Interval Between Onset and Death													
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To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier Check only one) Certifying F	Physician: To the best of aminer: On the basis of and mannar sta	axaminetion en	, death occurred d/or investigetion	et the tire, in my o	me, dete en pinion, dee	nd plece, er eth occurred	nd dua to tha ca d et the time, de	usa(s) and ma ete end plece,	annar es si end due to	atad. the ceusa(s)			
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name, (Figst, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 14:05 Ond December 21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1₩ M 2□ F Days Yrs. 48 Director 215-60-7163 11-08-51 MD **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MYes 2□No Director MD NA Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 5018 Goodnow Road Apt. "D" 21206 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ②□No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: n Yes, Give Year or Dates: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health end Mental Hyglen Important: If them 27 ie marked other tha eny injury or other treumatic event, that page. 12th Grade B.S. Degree Morgan State Univ. Accountant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Elmer Carroll Doris Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 Carroll Myra 5018 Goodnow Road Apt. "D" Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D'Buriat 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12-28-99 Baltimore, dure of Funeral Service Lice 22. Name and Address of Fecility Baltimore, Maryland WM.C.March FH 1101 E. North Avenue is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the on each line. Approximate Interval Between Onset end Deeth Phirtf. Enter the disease, or con shock, or heart failure. List only **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Stoma. Examiner Due to (or as a consequence of) inding physician and use as the buriaf-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 2 X No 3 Probably 4 Unknown signed b Supression P 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? r this certificate has here 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital at or Attending Physicien: T s effer death. If Director: Atter this certificet ad in by the funeral director, p. 8 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of De 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural
2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or Within 24 hours eff To the Funeral Discompletely filled in edical Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a, Certifier 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) John Hopkins Hos noul 10we

State Registrar

Date filed (Month, Day, Year)

29

1999

2. Registrar's Signa

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nema (First, Middle, Last). 2. Deta of Death Month 3. Time of Death **Physician** JOHN CORNELL JR. DEC 25 1999 11:15 /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 706 Karen Drive Kingsville Baltimore 5. Social Sacurity Number If Undar 1 Year If Under 24 Hrs. 6. Sax 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 28 F Months Days Min 216-34-6288 62 Yrs. Director Oct. 14 1937 Maryland Usuel Rasidence of Decedant 10a State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Kingsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 706 Karen Drive 21087 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 12 Yas 2 ☐ No 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after near of Healin and Mental Hygiene.

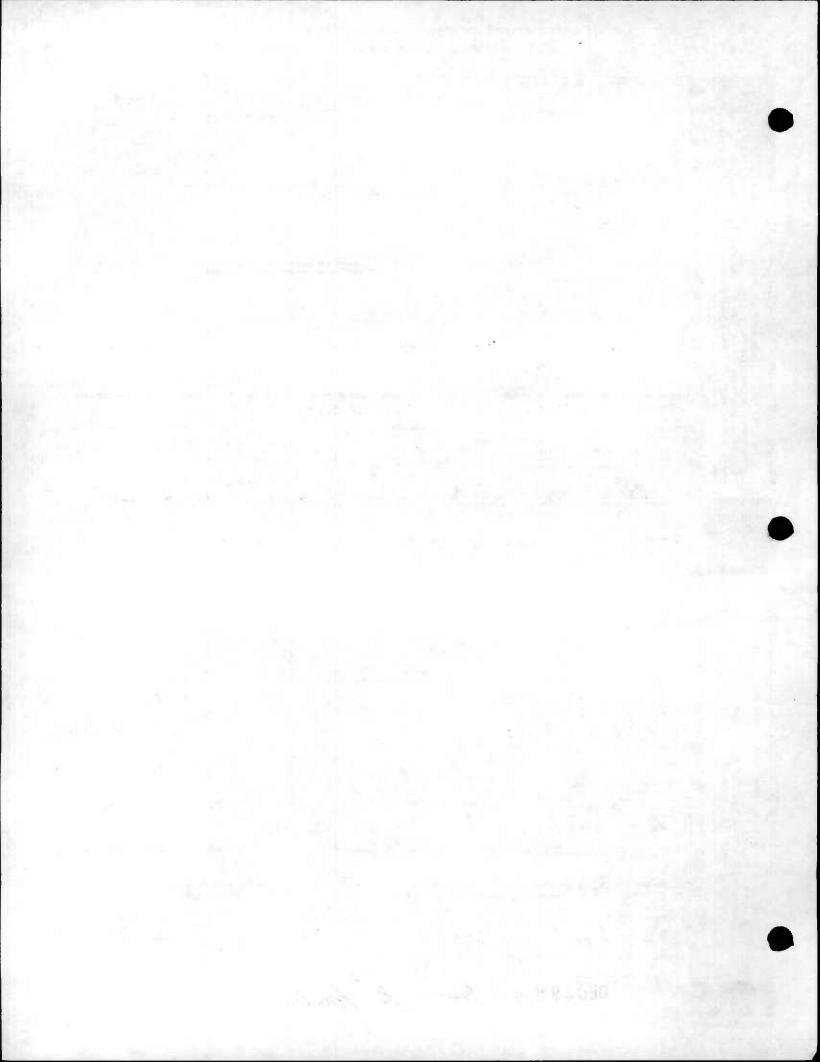
The result is the fired other than "natural, or he are yo other traumatic event, the Medical Exteriories 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Vas Giva White Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Longshoreman **DundalkMarineTerminal** 12th 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be John Leroy Cornell Sr. Loretta King 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patricia Cornell / wife 706 Karen Drive Kingsville MD 21047 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) DulaneyValleyCemetery 12/29/99 Baltimore MD. 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest.

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23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest.

Intervel Between Onset end Deeth. **Physician** Immediate Ceuse (Finat disaasa or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Couse (Disaasa or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): physician s the burial P.O. Box 68760. Dua to (or as a consequence of): for use as Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by Division of Vital Records. been signe should be 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 0 No certificate funeral director, Be 25. Wes casa ratarred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yas ZINO Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) edicai Certification: To 1 Inpatiant 2 ER/Outpetient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 24 hours after death.

Funeral Director: A 1 Yas 2 No 2 Accidant 6 ☐ Could not be datarmined 3 Sulcide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as steted.
2 Medical Examiner: On the basis of examinetion endor invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian completely (Check only one) within 2 ŝ 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) cause of deeth (Item 23a) (Type, Print) 30. Nama and addrass of person who complat Univ. 32. Registrar's Signatura State Registrar

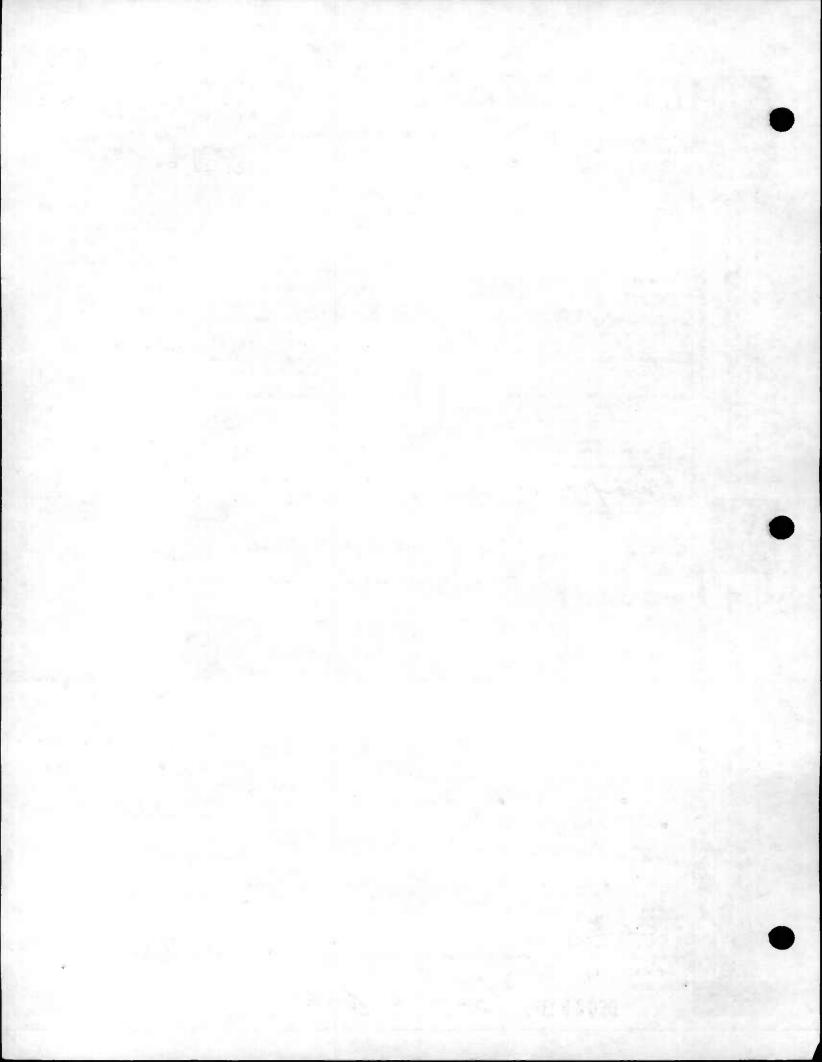


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician COULTHARD 1443 12 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARYUND med. System BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 28 F 213-54-1192 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7014 FITZPATRICK DRIVE 20707 USA pemit. Peges 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any injury or other treummatic event, the Medical Examiner must 2006. or Herns 23s 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTS MANAGER U.S. CUSTOMS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ROBERT F. NOVOTNY ALMA SHINNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MICHAEL J. COULTHARD/HUSBAND 7014 FITZPATRICK DR., LAUREL, MD. 20707 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Deurlei 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SACRED HEART OF JESUS12/29/99 BALTIMORE, MD. 21. Signature of Funerel Service Ligensee 22. Name and Address of Fecility CHARLES S. ZEILER & SON, INC. M20521 18, or complications that caused the death. Do not enter the mode List only one cause on each line. EASTERN AVE BALTÍMORE / Approximate Intervel Between Onset and Death 23a. Pert1. Enter the disease shock, or heart failure. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Versus Examiner Due to (or as a consequence of): Physician/Medical Examiner Acute Lymphocy tic The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be d Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? certificate 1 ☐ Yes 2 PNo 1 ☐ Yes 2 No To the Hospital or Attending Physician: "within 24 hours after deeth.

To the Funeral Director: After this certifice completely filled in by the funeral director; p 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitet: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 | Yes 2 | No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end title of pertitier 29c. License number 29d. Date signed (Month, Day, Year) 12436 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC SHOW 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State parks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Mildred Cline felter December 10.13pm 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Sykesville Copper Ridge Carrol If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year Months Days 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Virginia 1 M 2 F 87 Yrs 230-05-3316 April 18, 1912 Usual Rasidanca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Columbia Howard 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21044 11224 Ridermark Row U.S.A 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Marriad 1 ☐ Yas 2 No Spacify: Specify: White 3 Widowad 4 □ Divorcad 15. Dacadant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry at home Elamantary/Secondary (0-12) Collaga (1-4or 5+) homemaker 12 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Robert Jackson Doyle Eva Belle Obenchain 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Streat and Numbar or Rural Routa Numbar, City or Town, State, Zip Coda) 11224 Ridermark Row Columbia, Maryland 21044 Ms. Alice Wolf Daughter 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) All County Cremation Services, Inc. 12/22/1999 Sykesville, Maryland 21. Signature of Funeral Sarvica Licansee 22. Nama and Address of Fecility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Daath Pulmonary Immadiata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaguanca of): Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings eveilabla prior to complation of cause of daath? 24a. Was an autopsy 1 Yas 2 XNo 1 ☐ Yas 2 ☑ No 25. Was casa rafarrad to medical examinar? 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpetiant 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Devatural 5 Panding invastigation

Examiner The law requires that the death certificate be executed attending physicien end for use es the bunal-tran P.O. Box 68760, signed by the a Division of Vital Records, peeu paga 2 s certificate To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifica completally filled in by the funeral director, I

Examiner Physician/Medical Completed by Be 10 Certification: Medical

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Funeral

ģ

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shor traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "ne any Injury or other traumetic event, the Madity 2006.

Physician

/Medical

filed within 72 hours after

Baltimore, Maryland 21215-0020

O State Registrar

DHMH 16 Rev 6/95

31. Data filad (Month, Day, Yaar)

29b. Signature and titla of cartifian

2 Accidant

4 Homicida

(Check only one)

3 ☐ Suicida

29a. Cartifiar

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify)

29c. Licansa numbar

1 ☐ Yas 2 ☐ No

29d. Data signad (Month, Day, Yaar)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who completed causa of death (Itam 23a) (Typa, Print) 710 Obrecht Road, MD 21784 EINestine Wight Copper Ridge

32. Ragistrar's Signatura

DEC 2 9 1999

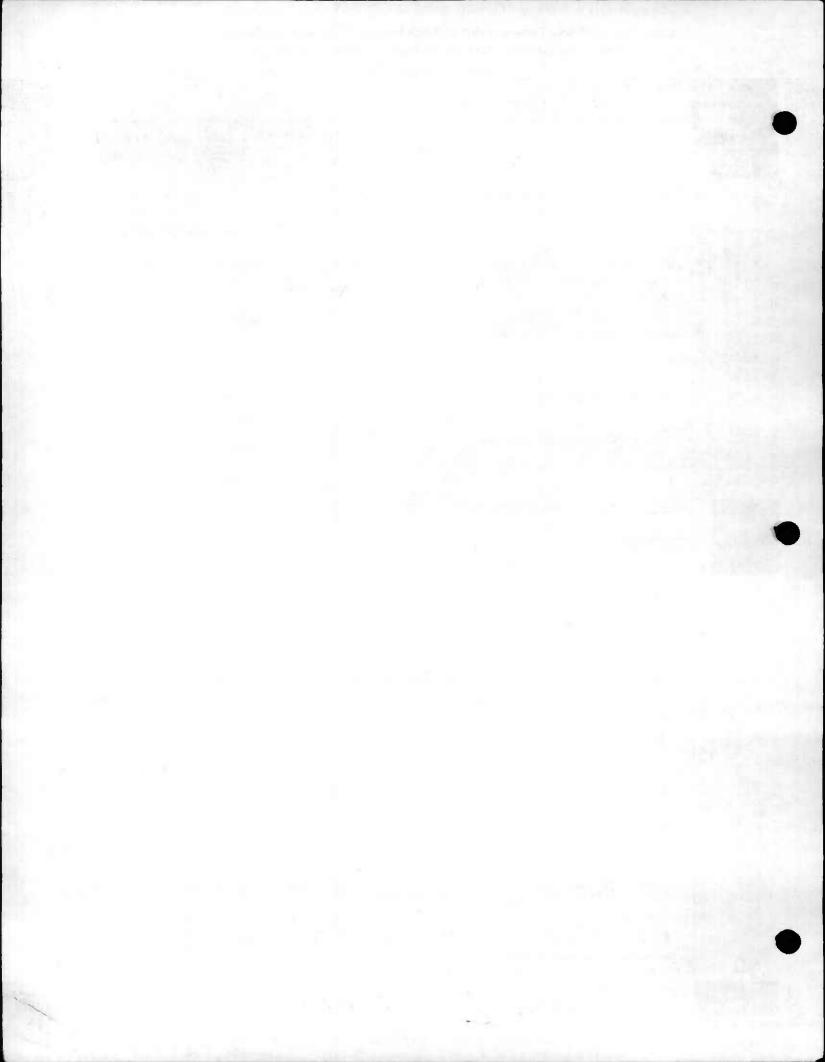
6 Could not ba

Mesting



1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

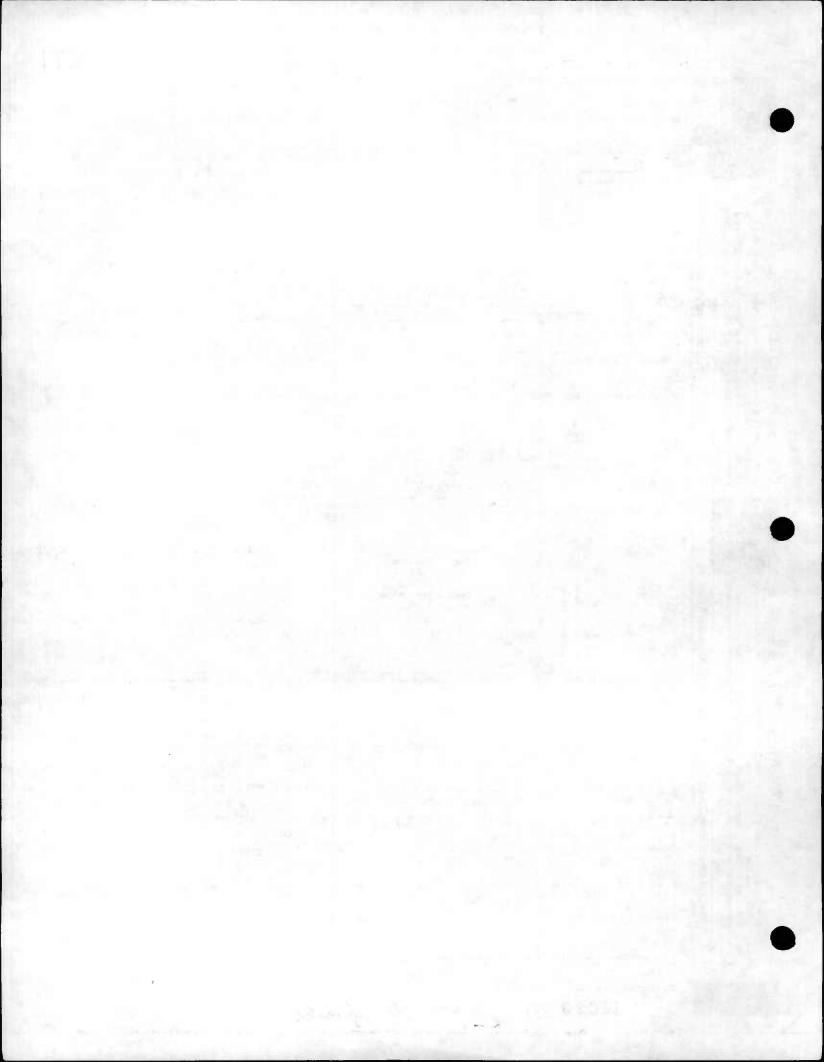


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Item: 5 per F.H G-779 1/20/2000 reb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Data of Death 3. Time of Death Physician Ralph E. Claggett 3:47 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Woodbine
| Funder 1 Year | Funder 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2921 Florence Road Howard 6. Sex. 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 217-30-1097 Months Yrs. Director 127-30-1097 Usual Residence of Decedent 70 Maryland 10a Stela 10h Count 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director r 28a-f Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 6 se filed within 72 hours after death with al Hygiene. I other than "natural", or flame 23e or went, the Medical Examine, must be 21797 2912 Florence Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No M Yes, Give Year or Dates: KOTCA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: 30 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Howard County** Mechanic 6 permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy
Important: if Item 27 is marked othe
any Injury or other traumatic event,
pages. 17. Father's Name (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be 2 Grafton Claggett Beatrice Clarey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 2912 Florence Road Woodbine, Maryland 21797 Mrs. Catherine Miller Sister-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) Crest Lawn Memorial Gardens 12/28/1999 Marriottsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lel M01204 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043. 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical 11/2 4/405 OAT UM nestreno Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of). Box 68760. The law requires that the death certificate be that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? À 18 Yes 2 No 3 Probably 4 Unknown signed b Records, à 24b. Ware autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yas 2 ☑ No this certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director. Be 25. Was case refarred to medicat 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 \$ Rasidence 6 Othar (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide n 24 hours at Funeral Di bietely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29b. Signature and little of certifie 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who comp leted cause of death (ttem 23a) (Type, Print) 5540 Ten Oaks Road Clarksville, MD 21029 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 9 1999 Registrar Sparker DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Nec 27 1999 1:00 AM WILLIE OUEEN CLARK /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath **Examiner** DEATON MEDICAL CENTER BALTIMORE CITY if Undar 1 Yaar | If Undar 24 Hrs. Birthpiaca (Stata or Foraign Country) 6. Sax 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 87 Yrs. 1 ☐ M 280X 230-18-9978 Director VIRGINIA FEB. 9 1912 Usual Residence of Decedent the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other treumatic event, the Medical Expansion must be notified at 1 Vas 2 □ No Director BALTIMORE CITY MARYLAND N/A 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Coda with 2821 HILLSDALE AVENUE 21215 U.S.A. Funeral death 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas ≥ XXIVIO If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whifa, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2XXNo Specify: BLACK Specify: 2 3XXWidowed 4 □ Divorced Completed 16b. Kind of Businass/Industry 16a. Decedant's Usual Occupation 15. Decedant's Education (Specify only highast grada completed) (Giva kind of work dona during most of working lifa. DO NOT usa retired) al Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) HEALTH NURSING AID 12th grade permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If item 27 is marked othe any injury or other treumstic event, page. 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be LEWANNA WALKER JOHN R. WALKER 2 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Myrine E. Buford/Daughter 2101 Callow Avenue, Baltimore, Maryland 21217 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2XXCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) METRO CREMATORY 12/28 BALTIMORE, MARYLAND 21. Signature of Funaral Servica Licensee 22. Nama and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA lown 1206 W NORTH AVENUE 236. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** disoure /Medical Immediata Causa (Final disaase or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner y partonslar buriel-trensit Sequantially list conditions, if any, laeding to immadiata causa. Enter Underlying Ceuse (Disease or injury that initiated evants rasulting in daath) Lasf pue Dua to or as a consaquanca of): 1 4m (2 homi pavery ettending physicien Physician/Medical the (or as a consequanca of) 80 950 Po ed by the e Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Ware eutopsy findings availabla prior to complation of causa of death? Completed 24a. Was an autopsy peeu has page 2 1 Yas 2 No 1 Yas 2D No certificate director, Be 25. Was case rafarrad to medical axaminar? 26. Placa of Daath (Check only one) Hospital: 1 Inpatiant Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) P 1 Yas 2M No 2 ER/Outpatiant 3 DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. fnjury et Work? Certification: After or Attending 1 Natural 5 Panding efter death.

Director: After din by the fur 1 TYas 2 No Investigation 2 Accidant 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, offica building, atc. (Specify) 4 Homicida Hospital 24 hours edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to tha causa(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurrad at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29d. Data signad (Month, Day, Year) 29b. Signatura and titla, of certifier 29c. Licensa number D30494 30, Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print), I say charles sheet Balkmae mn < 1229 DESAMO 31. Date filed (Month, Day, Yaar) 32. Registrar's Signatura State Registrar

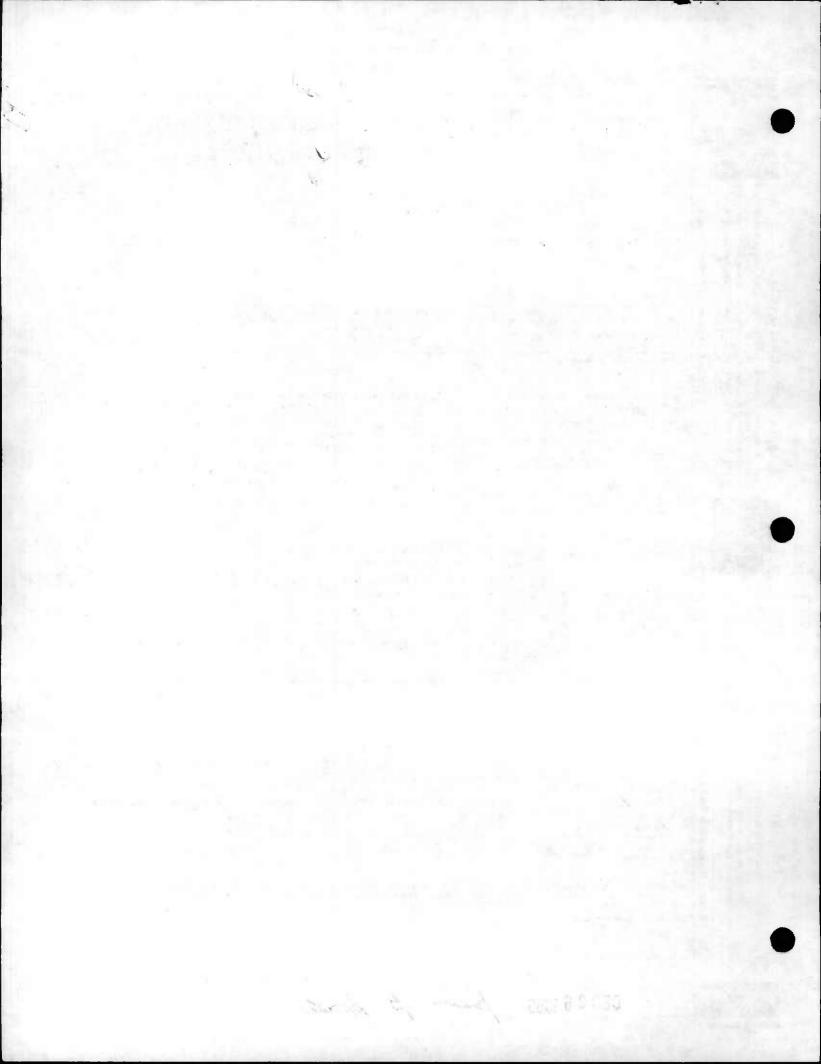
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					Ce	rtificate	e of	Death			Reg. No.		7	
	Physician /Medical		Charles R. Carlson								r 26, 199	9 Year		me of Death 30PM
	Examiner	4a Facility Nama (If not institution 2300 East Bal		4b. City, To Balt				County of Death						
	Funeral Director	5. Social Security Number 229-02-3925 Usual Rasidance of Decedant	6. Sex 1 2 M 2 F	7. Age (In yrs. last birthday) If Under 1 Yes Months Day					24 Hrs. Min.	Ins. 8. Data of Birth In. 10/25/1965 9. Birthplace Virgin			lace (S	itate or Foreign a
	ter ahow	10a. Stata 10b. County MD N/A									1		ide City Limits	
4	r from 23s or 28s-f al finet must be notified Funeral Director	10e. Street and Number 2300 East Balt	imore Str	ore Street 2122							10g. Citizen of What Country? United States			
020	filed within 72 hours after death with the Maryland Hygiena. Hygiena. Instrumation or 28e or 28e-1 show ent, the Marical Exeminer must be notified at Completed by Funeral Director	11. Marital Status 1 Navar Marriad 2 Mar 3 Widowed 4 Divorced	ried Armed F	2 No iva	U,S. 13. Was Decedent of If Yes, specify Cul			of Hispanic Origin? (Specify Yes uban, Mexican, Puerto Rican, et do Specify:			Yes or No- n, etc.) 14. Race - / Black, V Specify:		American Indian, Whita, atc. White	
Maryiand 21215-0020		15. Deceder (Specify only higher Elamentary/Secondary (0-12)	nt's Education st grade completed) College (College (1-40/5+)		16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Recruiter			pation during most of working ad)			16b. Kind of Business/Industr		
land	Baby @	17. Fathar's Nama (First, Middle, Murl Norman Ca	11.5								e, <i>Maiden Suma</i> Chwartz	ame)		
	Tis med	19a. Informant's Name/Relations Mr. James DiGir		end							ber, City or Tow Baltimo			and2122
baitimore,	Department of Hasil Department of Hasil Important: If item 2 any injury or other pace.	20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 4 □ Donation 5 □ Other (S	Specify)	State Hill	nce of Dispo metery, cred top Set	natory or of	her plac		1	Data .2/29/99	20c. Location			ita
	Department of Important: If any injury or phoe.	21. Signature of Funaral Sarvice	& Day	ud	53	305 Har	ford	Road,	Balt	imore, M	Ruck, Inc aryland			
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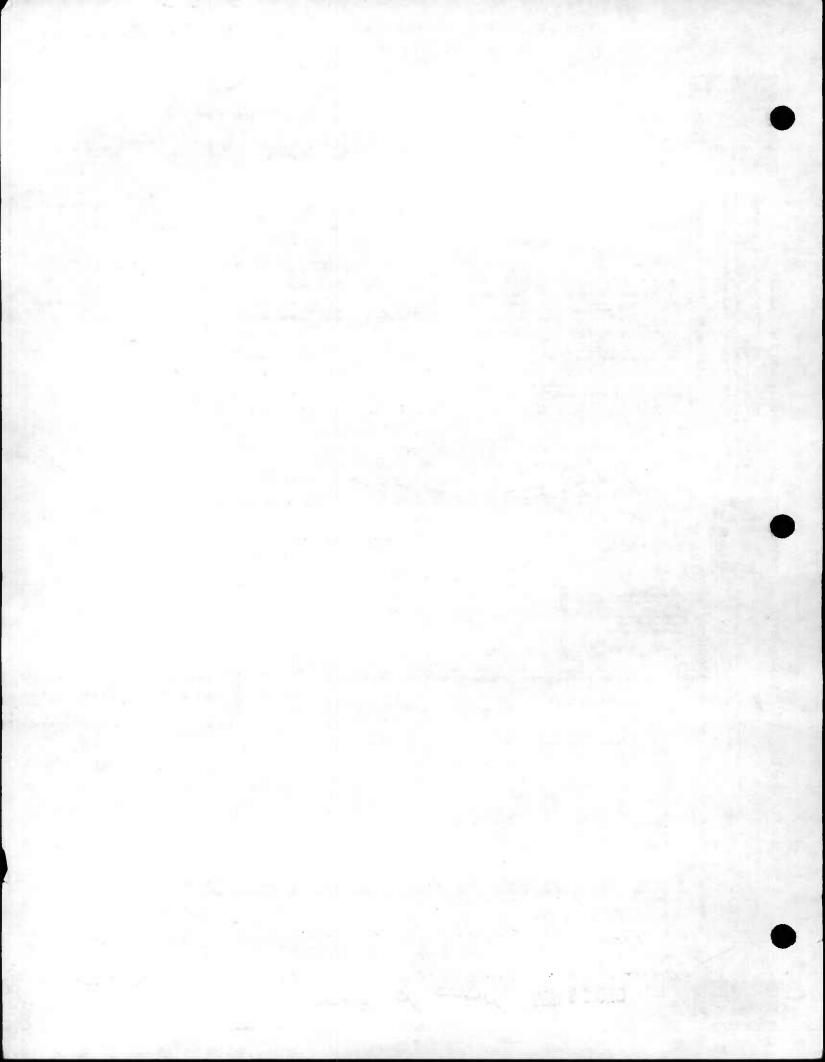
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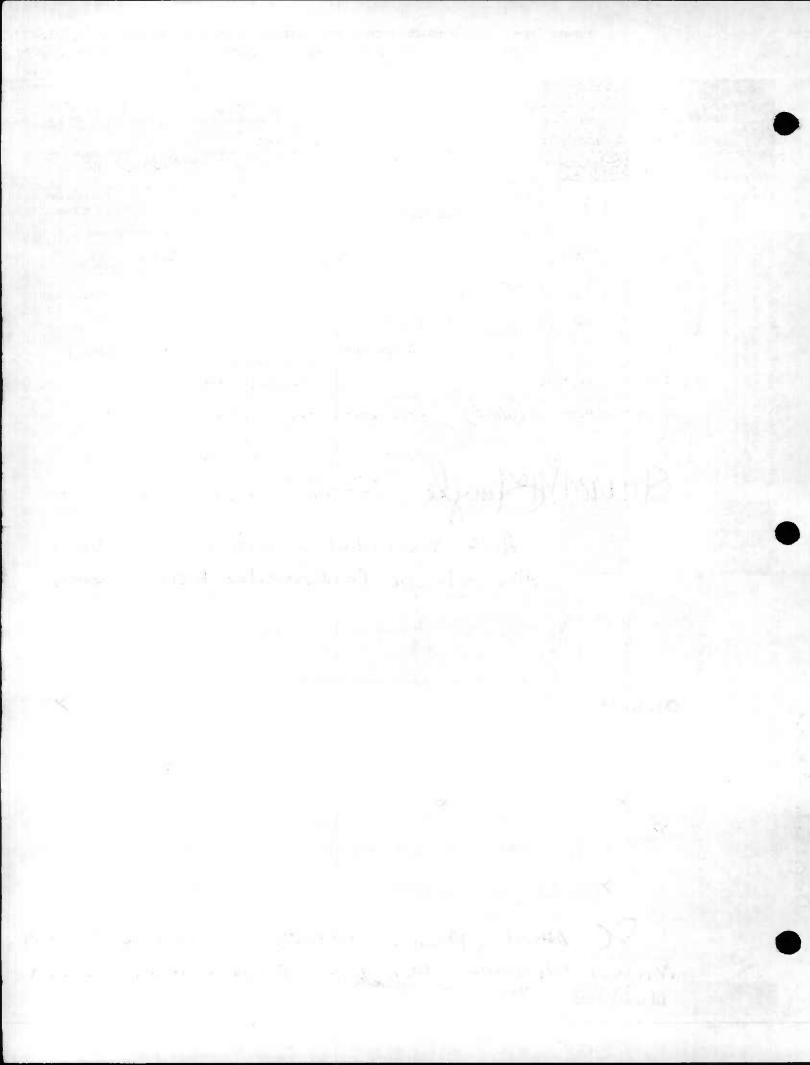
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Dav **Physician** Month Year John Edward Deppisch DECEMBER 24 1999 2:47 PM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Daath St. Agnes Hospital Baltimore 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 18, 1943 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foraign Country) **Funeral** ₩DM 2□F Days Yrs. Director 219-40-8131 MD Usual Rasidance of Decedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location Show 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1□Yes 2□No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 6015 Harford Ave. Funeral 21207 U.S.A. 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 1 ∰ Yas 2 ☐ No If Yes, Giva Yeer or Datas: 11/64-70 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) 11. Marital Status Black, Whita, atc. filed within 72 hours efter 1 Naver Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specity only highast grada complated) el Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mentel Hygies Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 12 Dispatcher City Government 17. Fathar's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Sumama) Be John Adam Deppisch Margaret Uler 19a. Informant's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Catherine Deppisch (WIFE 6019 Harford Ave. Baltimore, MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other place) Dete 20c. Locetion - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Woodlawn 12-30-99 Woodlawn, MD 22. Nama and Addrass of Fecility
Ambrose Funeral Home, Inc. tura of Funaral Sarvica Lie 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part1. Enter tha disease, or conshock, or haart failura. List only laath. Do not entar tha mode of dying, such as cerdiac or raspiratory errast, Approximeta Intervel Batwaen Onsat end Daath **Physician** Immadiate Ceusa (Final disaasa or condition resulting in daath) /Medical Myocardza Examiner Examiner rdiovascular Disease Athensclentic Sequantially list conditions, if any, laading to Immediata ceusa. Entar Undarlying Cause (Diseasa or Injury that Initiated evants rasulting In daath) Last Dua to (or es a consequence of): physician Physician/Medicai 6 Dua to (or as a consequenca of) 20 000 attending p Part il. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. thed 23b. Did tobecco use contributa to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown drasetes Division of Vital Records, by 2 24b. Wara autopsy findings availabla prior to complation of ceuse of deeth? Completed 24a. Wes en autopsy parformed? peed epasch, John certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese rafarred to medicel axaminar? 26. Plece of Deeth (Chack only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA 1 Yas 2 PNo 2 # 28e. Data of Injury (Month, Day Yeer) 27. Manner of De 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? After 1 Naturei 5 Pending Investigation death. 1 ☐ Yas 2 ☐ No 2 Accidant after death 6 Could not be 3 ☐ Suicida 28a. Place of injury - At homa, farm, street, fectory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stete) B 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely tilled it 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner es stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifian 29b. Signetury and titla of certifiar 29c. Licensa numbar 29d. Dete signad (Month, Day, Year) Physician 30. Nama and addrass of parson who complated causa of death (Item 23a) (Typa, Print) 90 Bakston Avenue Baltimore 21229 Silverman bearingstrar's Signatura State Registrar DHMH 16 Rev 6/95



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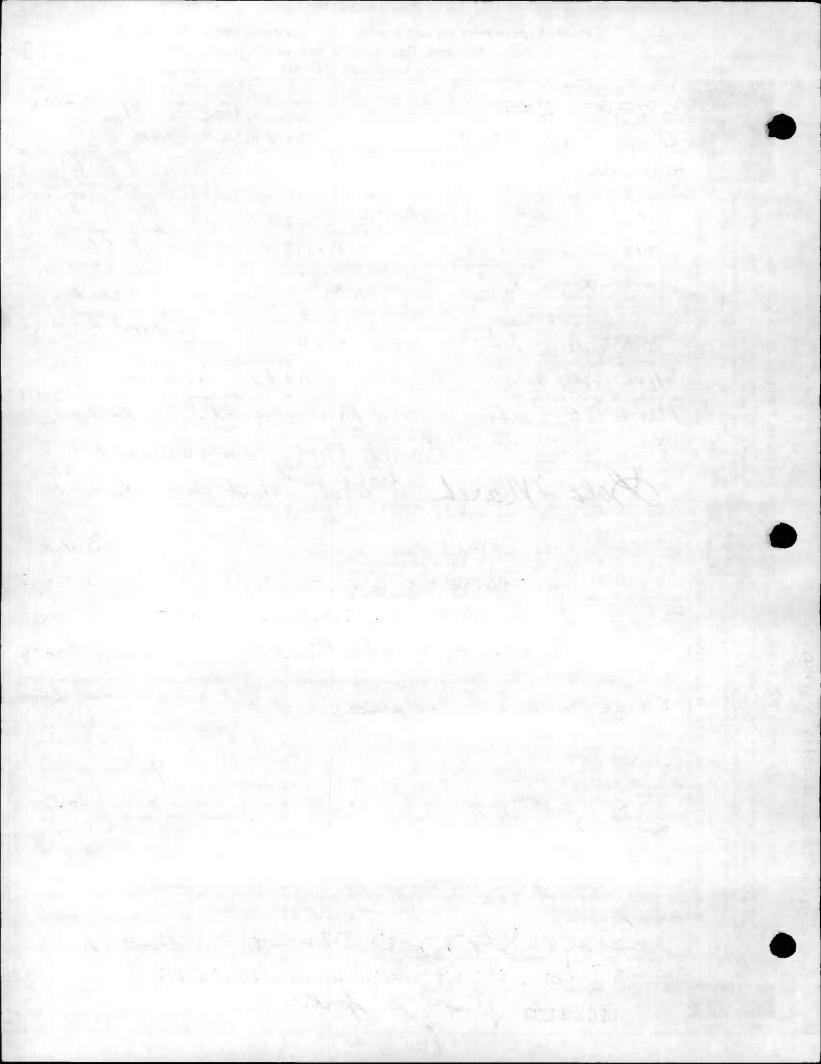
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ore			20e. Method of Disposition		2		Pleca of Dispo	osition (Ne	me of othar pla	ca)	Date	20c. Locat	ion - City or	Town, Ste	ta	
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Baltimore,	permit. Pa Departmen important: any injury		21. Signatureyof Fupdral S	ervice Licens	ee		2:	2. Name e	nd Addre	ss of Fecility		1.1-001	90		21215	
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0	ng Ph ter thi	ü	27. Mannar of Death 1 Naturel 5 □	Pending	28a. Data of (Month,	Injury Dey Year)	28b. Time o	đ	28c. Inju	ry et rk?	28d. Dascr	be how injury o	ccurrad			
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Division of	P eft ∈	edical Certification: To	3 ☐ Suicida 6 ☐ 4 ☐ Homicide	Could not be determined	28a. Plece o building	f Injury - At hi , etc. (Specif	oma, farm, st fy)	reet, facto	ry, office		28f. Location	on (Street and N Town, Stete)	lumber or R	urei Routa	Number,	
_	Hospital 24 hours Funeral stely filled	O TO	29e. Cartifier	ertifylna Phy	sician: To tha b	est of my kno	wiedne deat	h occurre	f et the tir	ma, data and nic	ace, and due to	tha causa/s) an	d menner e	steted		
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12/23/99

STEVE DOSS

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** It Under 24 Hrs. 8. Data of Birth (Month, Day, Year)

Wear Year 1999

4c. County of Death 4c. County of De 5100 /Medical 4b, City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner BACTIMORE NORTHWEST C'ENTER HOSPITAL If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Days 1□M 2√€ 82 Yrs. 213-18-7686 Director Nov. 12, 1917 Md. **Usual Residence of Decedent** 10a Stata 10b. County 10c. City, Town or Location tOd. Inside City Limits Md. n/a Baltimore 1 Xas 2 No Director 10e. Street and Number 10g. Citizen of What Country? 3312 Brighton Street 21216 238 12. Was Decedent Ever in U,S. Armed Forces?

to XYes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Stalus Black, Whita, atc. 1 Never Married ò 1 Yes 2€ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry General Services Admin. mentary/Secondary (0-12) College (1-4or 5+) US Govt. 11th Grade Maintenance Engineer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Isam 27 is marked other any Injury or other trearmetic event 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Charles Green Rosie Howard 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Bernadette Green Fleming 9809 Marriotsville Road Randallstown, Md. 21133 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removat from Stata 4 Donation 5 Other (Specify) Dec. 31 Baltimore, Md. Loudon Park Cemetery 21. Signature of Funeral Service Loon 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 41 23a. Part1. Entar the disease, or complications that cause the disease, or heart failura. List only one cause on each line. Approximata Intarval Batwean Onset and Death Do not enter the mode of dying, such as cardiac or raspiratory arrest, Physician Immediata Causa (Final diseasa or condition resulting in death) /Medical MONARY EMBOLUS Examiner Due to (or as a consequence of): Examine physician and s the burial-transit Sequentially list conditions, if sny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificata has t 1 ☐ Yas 2 No of Vital Attanding Physician: director. 25. Was casa referred to medical axaminer?

1 Yas 2 ANo B 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending death. o 24 hours after death.

Funeral Director: A letely filled in by the fu invastigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 Hospital The Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as ststed.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature and Ittla of certifier 29c. License number 29d. Date signed (Month, Day, Year) sau a Order MD WZZ751 December 26,1999

DHMH 16 Rev 6/95

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State

Registrar

NORTHWEST HOSPITAL CENTER, TOWN,

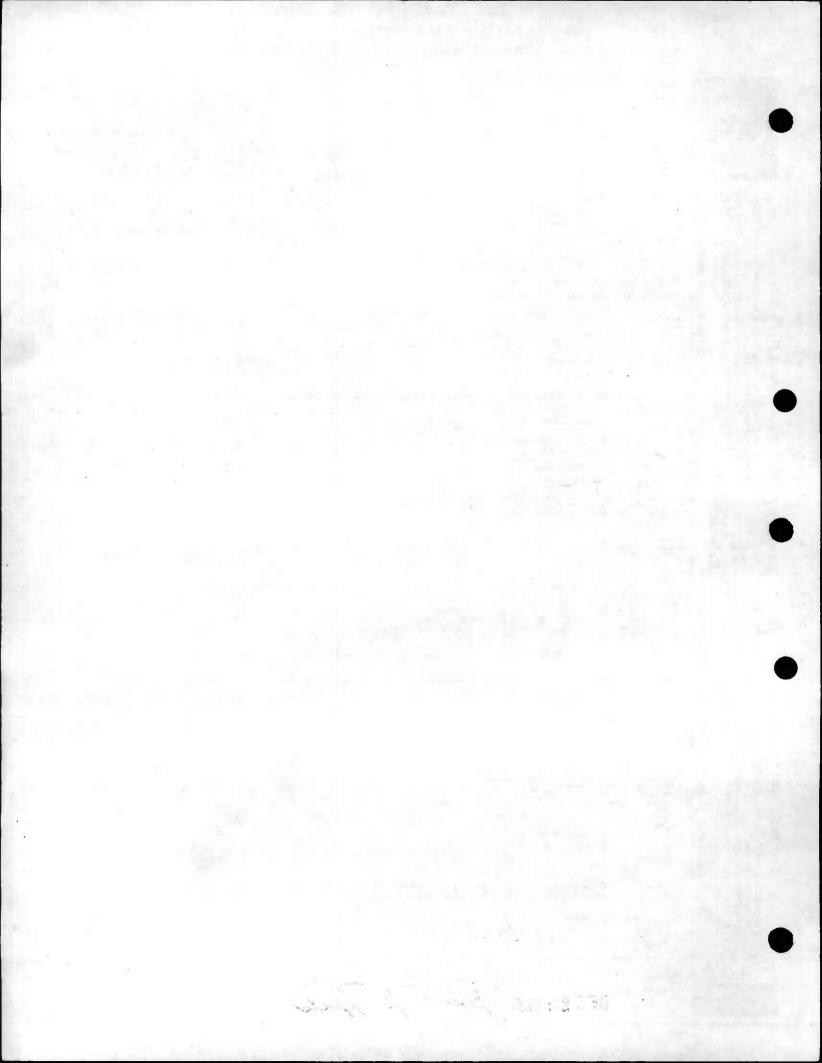
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

31. Data filed (Month, Day, Year)

OWENS

32. Registrar's Signature

Geneva



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40678 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Fendell Earl Davis 1999 2:25 AM DELEMBER 26 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** MAM 20 F Months Days Hours 217-20-8193 72 Yes. May 7, 1927 Director **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Md. Baltimore Lochearn 1 Yas 20No Director permit. Peges 1 and 2 should be filled within 72 hours efter deeth with the Mi Department of Health end Mentel Hyglene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f i eny injury or other treumatic event, the Medical Essentines must be notified page. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7805 Selgrave Road 21244 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, atc. 1 Never Married 2 Married 1 Yas 2 No If Yes, Give Year or Dates: 21215-0020 1 Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) University PKWY Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy 12th Grade Clerk Maryland 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillie Jackson Edward Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 7805 Selgrave Road Baltimore, Md. 21244 ENDELL Edith A. Davis wife altimore, 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal Irom Stata Jan. 3 Baltimore, Md. Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 11 21. Signature of Funeral Service 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 arri 23a. Part . Enter the disease, or complications that caused the shock, or heart lailure. List only one cause on each line. not entar the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Batween Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Que to (or as a consequence of): Examiner 3 DAYS PULMONARY EMBOLISM sician end buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s s the buriel Box 68760, Physician/Medical Due to (or as a consequence of): 997 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 s 1 Yes 2 No 1 Yas 25 No or Attending Physician: funeral director, B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1□ Yes 2⊠ No 2 After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 Natural efter death.

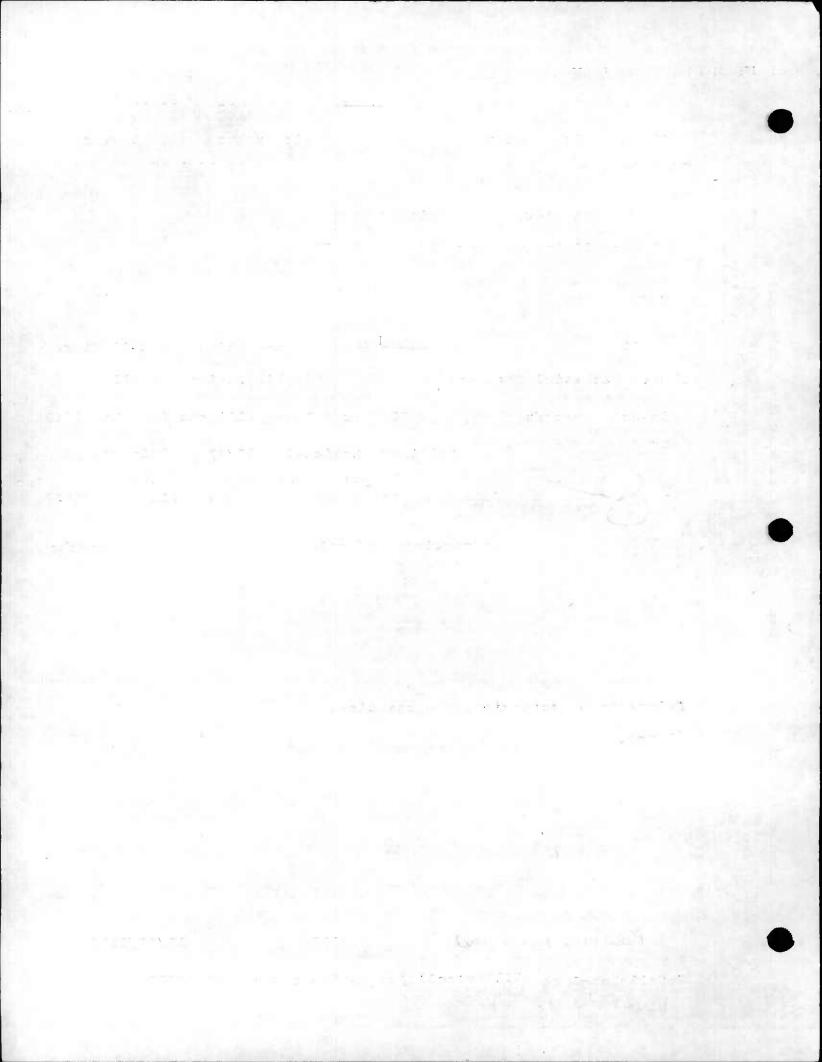
Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be delarmined 28e. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours or To the Funeral Completaly filled TECertifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a Certifier edical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-ppd Thomas a. Cumbo- MD DELEMBER 21, 1999 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 2401 WEST BELVAPERF AVENUE HOMAS ANTHONY CUMBO SINAIHOSPITAL OF BALTIMORE BALTIMORE, MARYLAND 21215 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State DEC 2 9 1999 Registrar

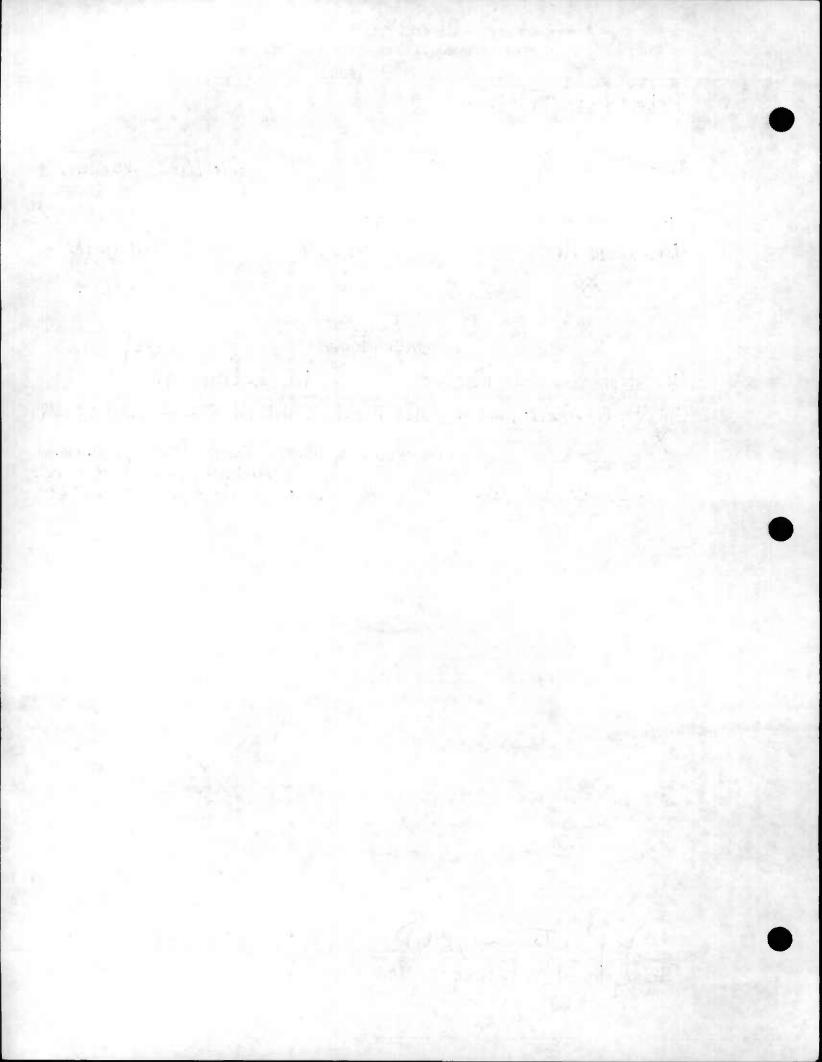
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State of Maryland / Department of Health and Mental Hygiene Q Q 40679 AMENDED ITEM #1 & 16a PER MD & FH G779 1/5/2000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year Month **Physician** NATHALIE 23 1999 6:45a.m /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Gaithersburg
| If Under 24 Hrs. | 8. Date of Wilson Health Center Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) 03 16 19(Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 2QF 215-09-8100 92 Yrs Director 1907 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show , or hams 23e or 28e-f sho arriner must be notified at 1 Yes 2 No Director Md Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 403 Russell Avenue, Apt 514 20877 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: white 1 Yes 2 No Specify: à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR OF Accounting 12 Retail Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) å Thomas Nathaniel Chambers Sophia Louisa Woodall 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Richard Subock/nephew 4862 Wharff Lane, EllicottCity, Md 21043 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 12/30 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and a such as cardiac or respiretory errest. interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Adeno carcinoma of colon months Examiner Due to (or as a consequence of). physician end s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see or injury) Due to (or es a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of): attending p 88 P.O. 1 by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Pulmonary Hypertension, Hypertension, Records, þ 24b. Were autopsy findinga available prior to 24a. Was an autopsy performed? Completed Deen Glaucoma completion of cause of death? has pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation or Attending 1 Netural efter death.

Director: After d in by the fur 1 Yes 2 No 2 Accident 6 Could nof be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours e Funeral D letely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(a) and menner stated. 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Pallahanty or no D41794 12/23/1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P-Callahan-Lyon
31. Date filed (Month, Day, Year)
DEC 2 9 1999 911 Russell Ave Gaithersburg, Md 20879 32 Registrer's Signeture State Registrar



DHMH 16 Rev 6/95



99-7641-510 jhm LUTHER

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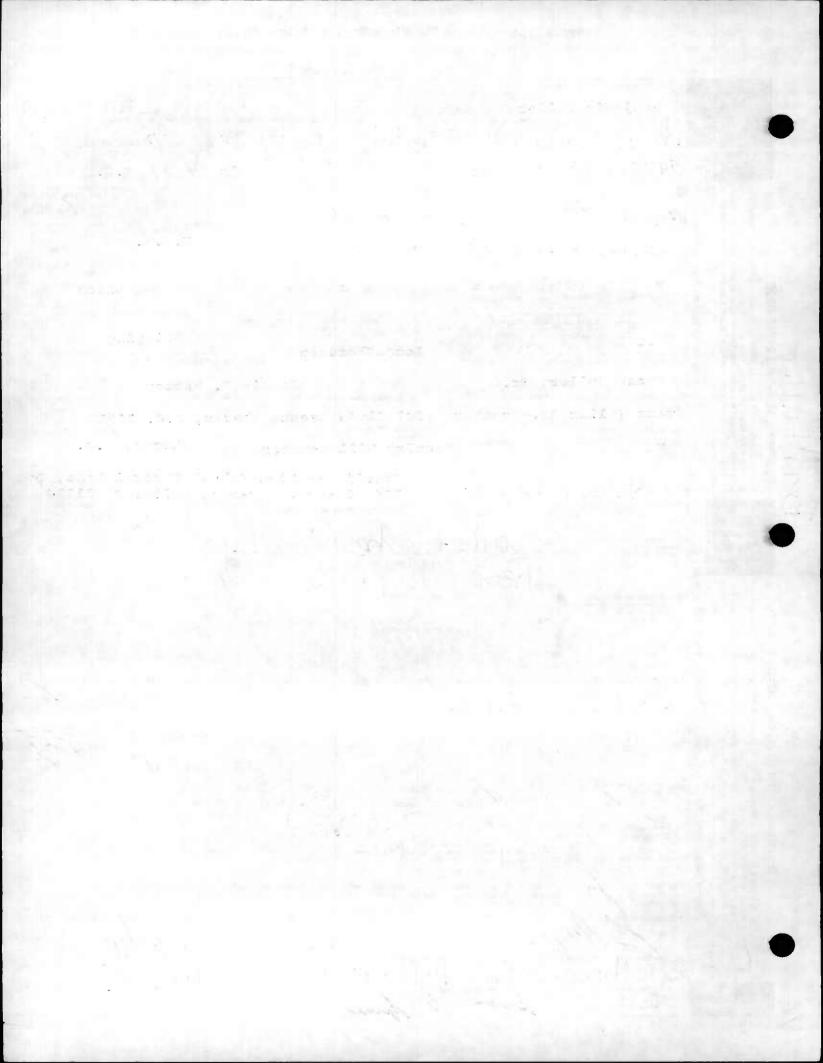
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ORD		State of Marylan		tificate of			eg. No.	J 4	1890
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Examiner	SINAI HOSPITAL				BALTIMORE		n/a		
Funeral Director	5. Sociat Security Number 6. Se 231–38–1253	7. Age (In yrs. 65	last birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 9,	Year) 1934	9. Birthp Coun Va .	ace (State or Foreign try)
Page 1	10a. State 10b. County	10c. City	y, Town or Loc	ation				10	Od. Inside City Limits
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5 0 D	10e. Street and Number 4401 Fairview Aver	nue Apt. B		10f. Zip Code	21216	1	0g. Citizen of V		try?
21215-0020 d within 72 hours after death open. er than 'netural', or here 23 the Medical Exerciner must completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U, Armed Forces? 1 ☐ Yes ♣☐No If Yes, Give Year or Dates:		/as Decedent of I Yes, specify Cub ☐ Yes 25 No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, c	
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21215-0 ad within 72 ho yolene. ser than 'naturn it, the Medical. Completed	Elementery/Secondary (0-12) 7th Grade	College (1-4or 5+)	Labor		od)		Baltimo	ore Ga	as & Elec.
yland 2 build be filled Mental Hygi arked other afte event, 1	17. Father's Name (First, Middle, Last) Henry Ford				18. Mother's Name Mamie Wi	(First, Middle, I	Maiden Sumaп	ne)	
Mar nd 2 sho with and 27 is m	19a. Informant's Name/Relationship (Ty Bettye J. Ford	pe, Print) Wife			and Number or Rura V Avenue A				
Baltimore, semit. Pages 1 a separtment of Hes mportant: if Nem ny Injury or othe mat.	20a. Method of Disposition 1 Kosuriat 2 Cremetion 3 R 4 Donation 5 Other (Specify)	emovet from Stete	emetery, crem	ition (Name of atory or other pla emorial	'	Date c. 28 B	20c. Location - altimor		
Balt pemit Depart Import any inj	21. Signature of Funeral Service License	e. hutte			ess of Facility Nut ns Falls P				
Control of the contro	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events	Due to (or	r as a consequer as a consequer as a consequer	ence of):	ards,	rajeli	er l) is ea	vse
- P 00 4	resulting in death) Last		40 4 00110040					t	
O . 42 E	Part II Other significant conditions con	tributing to death but not resu	ulting in the un	derlying cause gi	ven in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
that the of the detached y Physic	Watertes The	Miths				1 🗆 Y	s 2 No	3 Prob	ably Unknown
al Records, The law requires the law requires the page 2 should be deem signed by Completed by						24a. Was a perform		ava	re autopsy tindings illable prior to npletion of cause leath?
The law are page 2 s						1□ Ye	s 2NNo	10	Yes 2□ No
stelant The cartificate frector, pag	25. Was case referred to medical examiner?			l au	26. Place of Deeth	(Check only on	e)		
T 4 4 5	27. Manner of Death	ospitel: 1 ☐ Inpatient 2 ☐ 28a. Dete of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju		me 5 Reside 28d. Describe ho)
VISI Atten er deat by the	2 Naccident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of tnjury - At ho building, etc. (Specify	me, farm, stre			28t. Location (St City or Town		er or Rura	Route Number,
To the Hospital or within 24 hours aft To the Funeral Dir completely filled in Medical Cer	20a Cattler 1 Certifying Phys	ician: To the best of my knower: On the basis of examinet and manner stated.	viedge, death of investigation and/or investigation	occurred et the tid estigation, in my d	me, date and place, opinion, death occurre	end due to the ca ed et the time, da	ause(s) end me ate end plece,	enner es st and due to	ated. the cause(s)
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1	1 Santoles	(UU)		001	Œ		DECEMBE	R 20,	1999
0	30 desires and address of person who co	LEND	111 Pe		et, Baltim	ore, Ma	ryland	21201	
State Registrar	31. Date filed (Month, Day, Year) DEC 2	32. Registrar's Signal	ure	B. Sp	rocks				

DHMH 16 Rev 6/95

Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** arember 1999 Benjamin Fuller * /Medical Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lang senera more N/A If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. **Funeral** Days Months Hours 1 M 2□ F 7567360 Yrs Director S.C. 62 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A 1 1 Yes 2 □ No h and Mental Hygiene. I is marked other than "natural", or items 23s or 28s-f at traumetic event, the Medical Examiner must be notified 1.timore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1102 Druid Hill Apt. Ave. 21201 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Stetus 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Long Shoreman
18. Mother's Name (First, Middle, Meiden Surneme) 12 17. Father's Name (First, Middle, Last) Be should be ind Mental 2 Evans Fuller, Sr. Jannie B. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 Evans Fuller Jr.-Brother 307 Clyde Avenue Cheraw, S.C. 29520 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 20a. Method of Disposition Date Department of Important: If its Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ò Foundry Hill Cemetery 12/28 Cheraw, S.c. 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examiner TOY that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last physician and s the buriel-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) 98 Pol Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? been signed by the a 1 Yes 2 No 3 Probably 4 Unknown Records, py 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? page 2 1 Yes 2 No certificate 1 Yes 20 No Division of Vital or Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) OL 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending efter deeth. Director: Aft 1 Yes 2 No investigation 2 Accident the Funeral Director filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours e 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

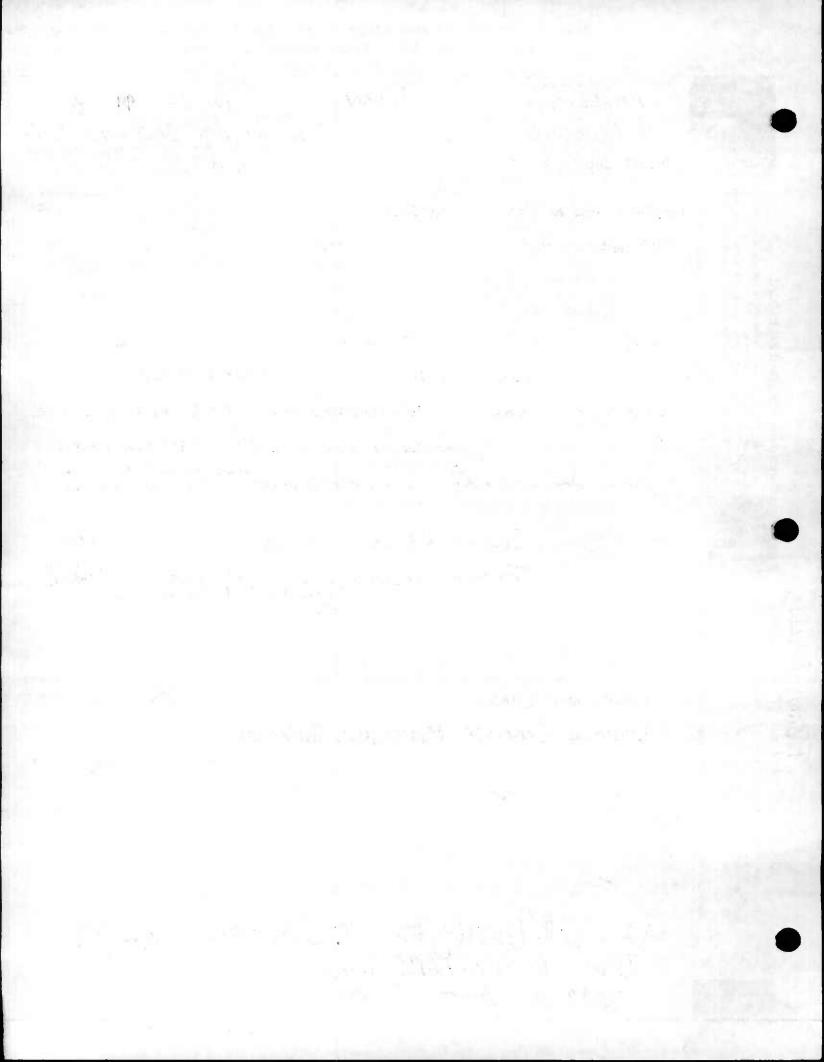
20 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29e. Certifier edicai (Check only one) To the I 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) end address of person who completed cause of death (Item 23a) (Type, Print) EOI 31. Date filed (Month, Day, Year) DEC 2 9 1999 32. Registrar's Signature State Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth 3. Time of Death PAGAN **Physician** 4YLLIS /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number, 4c. County of Death Examiner BALTIMORE BALTIMONE MOSPITAL MA If Under 24 Hrs. 5. Social Security Number 6. Sex if Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreig Country) **Funeral** 1 ☐ M 2 🛛 F Months Days Hours 214 40 1866 56 **Director** Maryland Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7819 Appletree Road 21122 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No if Yes, Give Year or Detes: 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Mildred Stroback Charles W. McClain 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Fagan 7819 Appletree Road Baltimore, Maryland 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 12/28/99 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Meadowridge Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Gonce Funeral Home P.A. emusinh 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) SEVERE METABOLIC ACIDOSIS Examiner THROMBOSIS OF INFERIOR VENA CAYA WITH
Due to (or as e consequence of): INVOLVEMENT OF ILLOWERNONAL anding physician end use es the bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last been signed by the ettending physician VZINS Physician/Medical Due to (or es a consequence ot): FASAN, PHYL Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco usa contributa to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown DULMONARY EMBOLUS þ 8 24b. Were eutopsy findings avelleble prior to completion of cause of death? POSSIBLE SUBACUTE MYOCARDIAL INFARCTUM page 2 should Completed 24a. Was an eutopsy performed? certificate has 2 No 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. completely 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Qey, Yeer) 30. Name end-MD. 900 CATON AVE 31. Date tiled (Month State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month Day **Physician** Stanley Grade December 033/ 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NΔ of BAHIMORE HUSDIOL Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Vrs Director 219-58-7489 46 VA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore Director MD NA XIX Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? USA 1028 Woodson Road 21212 Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: 1□ Yes 2□No Specify þ Specify: Black "natural". Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Haalth and Mantal Hygiena important: If Itam 27 is merked other than any injury or other traumatic event, The Magnes. Elementery/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mantal Hygiena. Baltimore City 10th Grade Janitorial School System 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Clayta Fears 0 Thomas Grade 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21212 19a. Informant's Name/Relationship (Type, Print) 1028 Woodson Road Baltimore, Maryland Clayta Grade 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages X Burial 2 Cremation 3 Removal from State 12-29-99 Wake County, VA Wake Forest Comm. Ctn. ins of Funeral Service Li 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue III. or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest List only one cause on each line. Approximete tntervat Between Onset and Death Part L Enter the disease shock, or heart failure. **Physician** Immediate Cause (Finat disease or condition resulting in deeth) /Medicai SIRSTION Theumania Examiner Due to (or es e consequence of) Examiner the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury pue Due to (or es e consequence of) Box 68760, nding physician requires that the death certificate be Physician/Medical that initieted events resulting In death) Last Due to (or es e consequence of) as 1 use ŏ Records, P.O. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown 2 200 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? Completed 24a. Was an autopsy performed' cartificate has page 2 1 Yes 25 No 1 ☐ Yes 2 M No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this cartified Be 25. Was cese referred to medical 26. Place of Death (Check only one) irs after death.

VI Director: After this call of the firm. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) end manner stated. 29a, Certifiei plately (Check only 29b, Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1815TER Resouv 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Meister Sinai 32. Registrar's Signature 31. Date filed (Month, Day, DEC 2 9 State

Registrar

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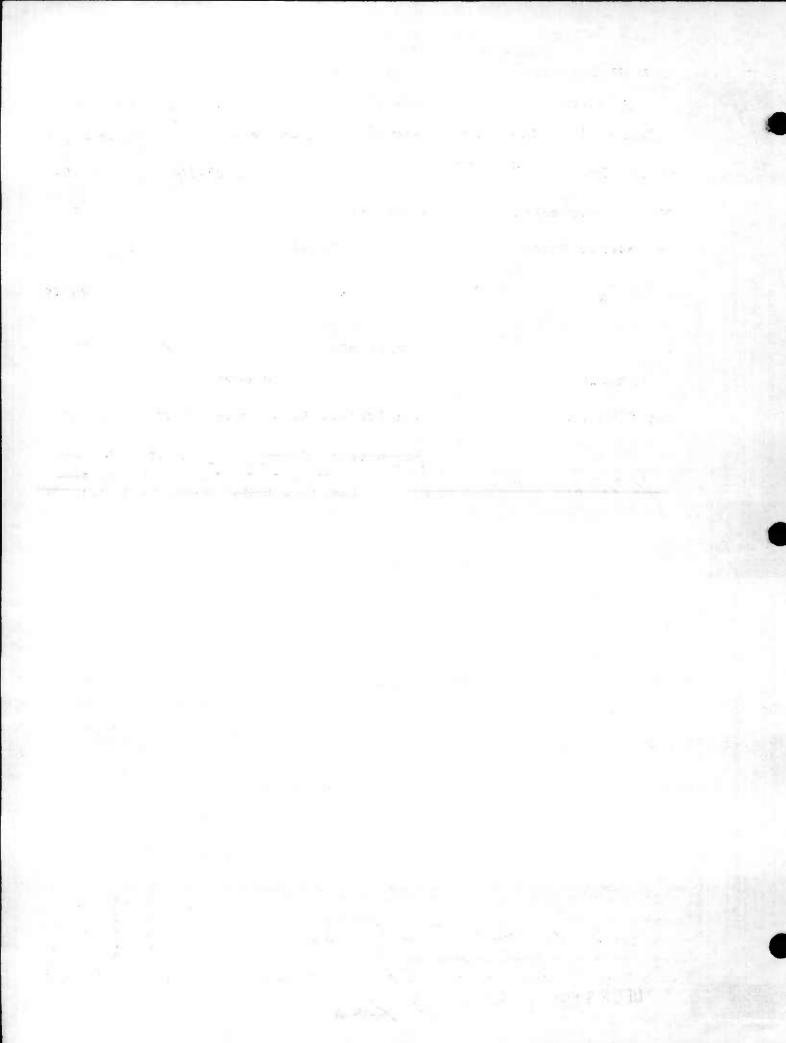
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DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #11 PER INFORMANT G779 1-3-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:10 Pm Madeline Catherine Gorman December 25 1999 4s Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 21, 1913 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Months 1□M 2□F Yrs. 220-54-6751 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Kingsville Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 7915 Redstone Road 21087 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married -- PM Mar 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walberga Matthew Bitzelberger Lindner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty Jane Smith (dghtr) 11902 Caspian Road, Kingsville, MD 21087 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/99 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licer 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . Acute Massive Right Cerebral Bleed. 12 Hours Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 Suicide

Examiner physicien end s the burlei-transit certificate has been signed by the ilrector, page 2 should be detached Division of After this deeth. ie Hospital or Attendi n 24 hours eiter deeth ne Funerel Director; / pletely filled in by the f

Physician

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Directo

Funeral

Director

Maryland 21215-0020

semit. Pages 1 and 2 should be Department of Health and Mental I mportant; if hem 27 te marked of

Physician

/Medical

Examiner

Physician/Medical

Completed by

8

Certification: To

Medical

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier (Check only one) 29b. Signature and title of of

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examinar: Op the basis of examination and/or investination in my spinion death accurred at the cause(s) and manner as stated. r. On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s)

29c. License number D18424 29d. Date signed (Month, Day, Year) DEC 26 1999

leted cause of death (Item 23a) (Type, Print)

HARFORD ROAD, FALLSTON, MD. 21047 1908

31. Date filed (Month, Day, Year)

DEC 2 9 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

To the Hosp within 24 hor To the Fune completely fi

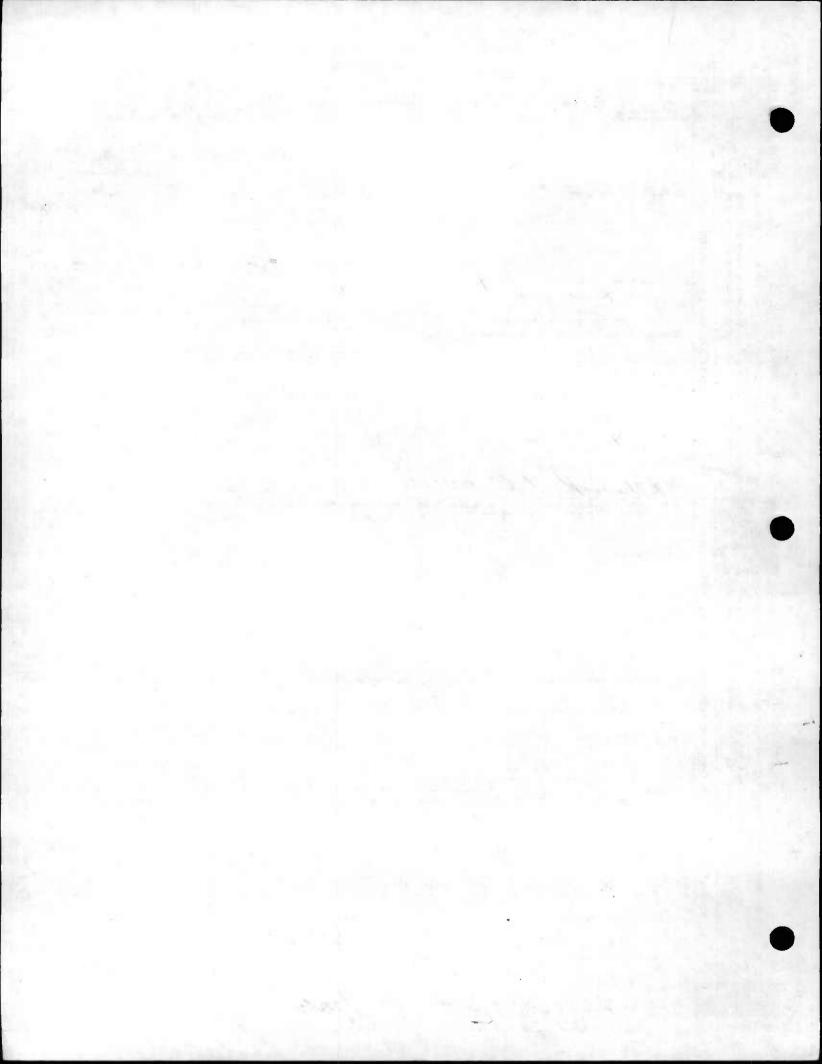
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tale Massive Right Gerebrat Breed . 12 Herrs Hipperfemation .

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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DHMH 16 Rev 6/95

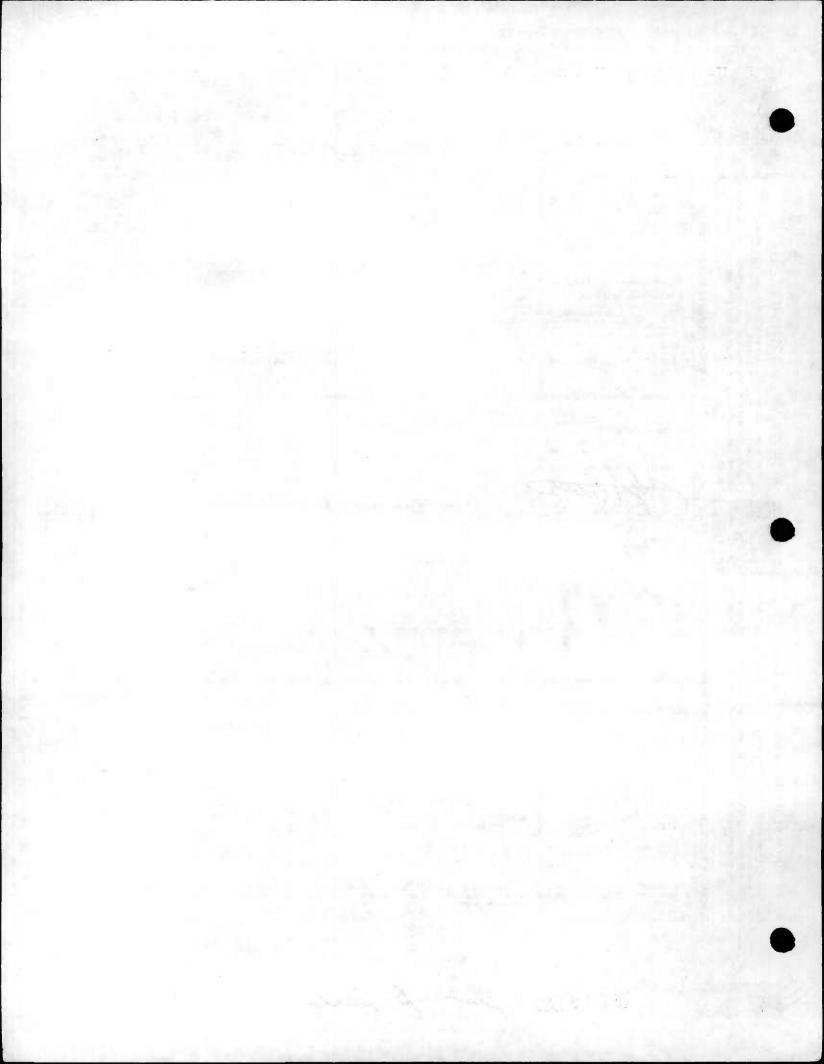


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death #5 PER MEO G779 1-11-2000 WR. Reg. No. 1. Decedent's Name (First Middle Last) 2. Dete of Death Dey 23 **Physician** Month RANDALL GORDON 6 pm DEC /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 5295 Rivendell Lane Columbia
If Under 1 Year | If Under 24 Hrs. Howard County 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 266-89-9934 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) Deys Hours 1 1 M 2 □ F Yrs. Director Dec. 14. 1964 Florida 10s. State 10b. County 10c. City. Town or Location 10d. inside City Limits filed within 72 hours after death with the Maryla Hygiens. Other the neturel, or frems 23s or 28s-f show and, the stadios Examiner mass be notified a 1 ☐ Yes 2 ☑ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5295 Rivendell Lane 21044 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygians important: If itam 27 is marked other the any Injury or other traumatic evant, the 1 page. 12Years
17. Fether's Name (First, Middle, Last) Computer Support Tech. Hotel Business Saitimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumame) Glen L. Gordon Judith Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Judith Gordon (Mother) 4021 Glen Garry Road W. Lakeland, FL 33813 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date NBurial 2 ☐ Cremetion 3 ☐ Removet from State 4 □ Donation 5 □ Other (Specify) Oak Hill Burial Park 12/29/99 Lakeland, Florida 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility.
Witzke Funeral Home of Catonsville, Inc. NEW 21228 1630 Edmondson Avenue Catonsville, MD Part / Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, such as cardiac or respiretory errest, and a remove of dying, and a remove of dying, and a remove of dying, and a remove of dying and a remove of dying. Approximate Interval Between Onset and Death **Physician** Atherosclerotic Cardiovascular Disease - Ischemia Immediate Cause (Final disease or condition resulting in death) /Medical Years Examiner Due to (or es a consequence of): Physician/Medicsi Examiner Hypertension Years Attending Physician: The law requires that the death carificate be executed physician and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): mellitus Box 68760, Diabetes eavs Due to (or as a consequence of): renal (dialysis dependent) failure months Records, P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cardiac arrhythmias (diagnosis unknown) 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Be Completed 24a. Wes en eutopsy performed? cartificata has 1□ Yes 2 No 1 Tes 2 No Division of Vital director, 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No After this To the Hospital or Attanding Phy within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death edical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturat 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Pfiedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dec 24, 1999 at my 1 ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemlock Cone Way Ellicott City MD 21042 PATRYCE TOME MD 4565 A. 31. Date filed (Month, Day, Year) DEC 2 9 32. Registrar's Signature State sarks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40689 Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Deta of Daath 3. Time of Death Month Yaar 26,1999 11:20 A.M Margaret E. Grogg Dec. 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Daath 4c. County of Death Eastpoint Nursing Home & Re-5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) Baltimore If Under 24 Hrs. Hours Min. B. Dala of Birth (Month, Dey, Year) Paltimore 9. Birthplece (State or Foreign Country) 216-05-1991 1DM 27F Months Days Oct. 24,1912 Virginia Usual Rasidence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. N/A 1 √ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 338 S. Macon Street 21224 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Orlgln? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, alc. 1 ☐ Yas 2 ☑ No If Yes, Giva Yaer or Datas: 1 Never Married 2 Married 1 Yas 2√ No Specify: Specify: White 3 Widowad 4 □ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Assistant Buyer Retail 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Henry Stone Allie Tillie Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) on 338 S. Macon St., Balto., Md. 21224 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Tow Wallace Grogg, Jr./ Son 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Moreland Memorial Pk. 12-30-99 Balto., Md. 21. Signature of Funaral Service Licens 22. Nama end Addrass of Facility Bradley-Ashton-Matthews Funeral HomeInc. 23e. Parth. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest. Approximate 22 shock, or heart failure. List only one cause on each line. MODIL Intarval Batween Onsat and Deeth Immediate Ceusa (Final diseese or condition rasulting in daath) CONGRETIVE 2 weeks HART FAILURE Dua to (or as a consequence of): Sequentielly list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disaasa or Injury Dua to (or as a consequence of): that initiated events rasulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown MINTIA 24b. Were autopsy findings available prior to 24a. Was en eutopsy complation of cause of death? 1 Yas 2 No 1 ☐ Yes 2 DONo 25. Was case rafarrad to medical 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 1 Yas 2 No 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 X Naturai

buriel-transit requires that the death certificate be executed P.O. Box 68760. ettending physiclan for use es the burie Records, certificate hes of Vital this

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Examiner

Physician/Medical

by

Completed

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2 Accidant 3 Suicida

4 Homicida

29a. Certifier

8

Funerai

Director

item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 72 hours effer of Department of Health and Mentel Hygiene. Important: If frem 27 is marked other than "natural", or item any injury or other traumatic event, the Mentel once.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0020

To the Hospital or Attending PP within 24 hours effer death.
To the Funeral Director: Affer th completely filled in by the funeral Division

Medical Certification:

State Registrar 29b. Signatura and title of certifiar Marther notherray wo

6 Could not be determined

29c. Licansa numbar D45757

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner es steted.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Nama and address of parson who complated causa of daath (Itam 23a) (Typa, Print)

TATTHEW MENTISNEY 5505 HOPKINS BAYVION CIRCLE

1 ☐ Yas 2 ☐ No

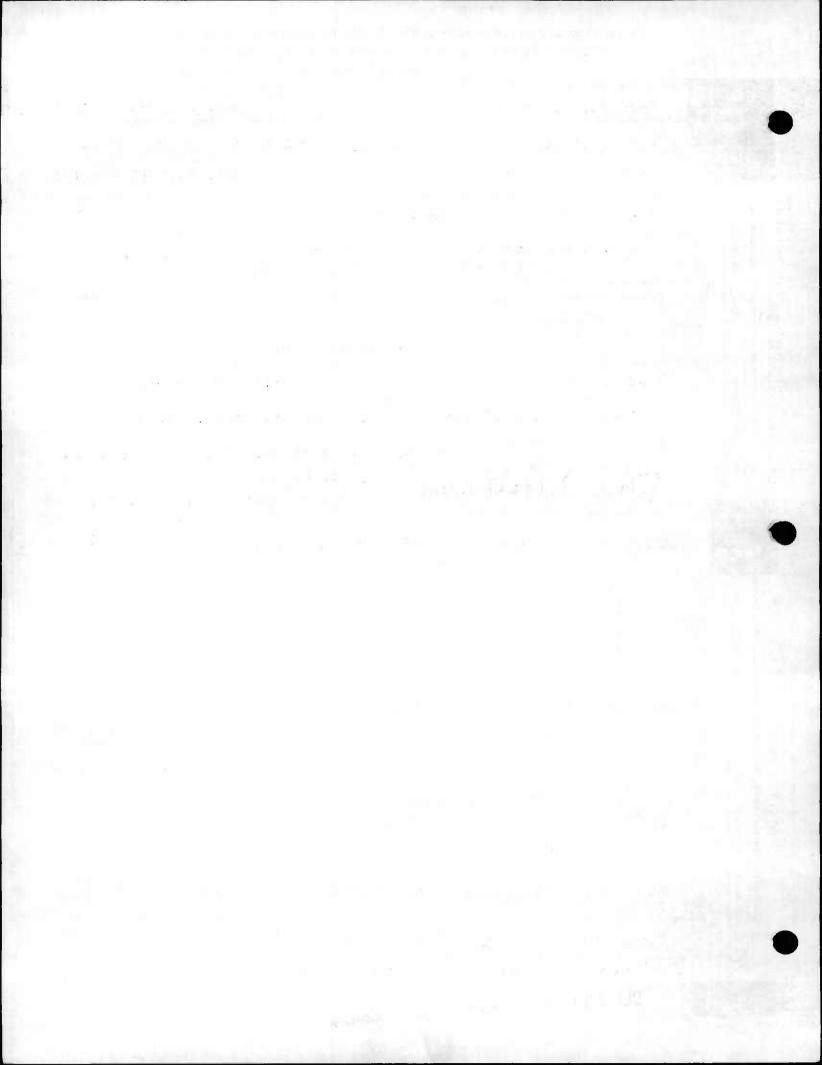
BALT NO 21224

31. Date filed (Month, Day, Yeer)
DEC 2 9 1999

32. Registrar's Signatura

28a. Piece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

& Sports



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40690 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** MILDRED V. GRUMBACH 12 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPAMZ BATIMORE, MD BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months. Hours 1 □ M 2 🛛 F 219-01-0554 78 Director March 9.1921 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show be filed within 72 hours after death with the Maryle ntel Hygiene.

Ind other then "natural", or flome 23a or 28a-f show event, the Medical Exam he must be notified at Baltimore Parkville 1 ☐ Yes 2 ☑ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9508 Avondale Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Technician Bendix Company permit. Pages 1 and 2 should be filt.
Department of Health and Mentel Hy
Important: if item 27 is marked oth
any injury or other traumatic evant
page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence McClaskey Mdlle Tracey 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara C. Foerster - Daughter 9508 Avondale Road Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1

Buriel 2 □ Cremation 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore National 12/30/99 Baltimore, MD 22. Name and Address of Facility
Baltimore, Maryland 21214 21. Signature # Funeral Service Licenses Cuboch Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Pert1. Enter the disease, or complication. The caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) CONGESTIVE HEART FAILURE N134RS Examiner CARDIOM YOPATHY Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last burial-trar Due to (or es a consequence of) The law requires that the death certificate be axecu ~13 9RS Records, P.O. Box 68760 ERIARTERITIS Physician/Medical Due to (or as a consequence of): ACUTE KENAL Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 214 No 1 Yes 1 □Yes 2 □ No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phywithin 24 hours after deeth.

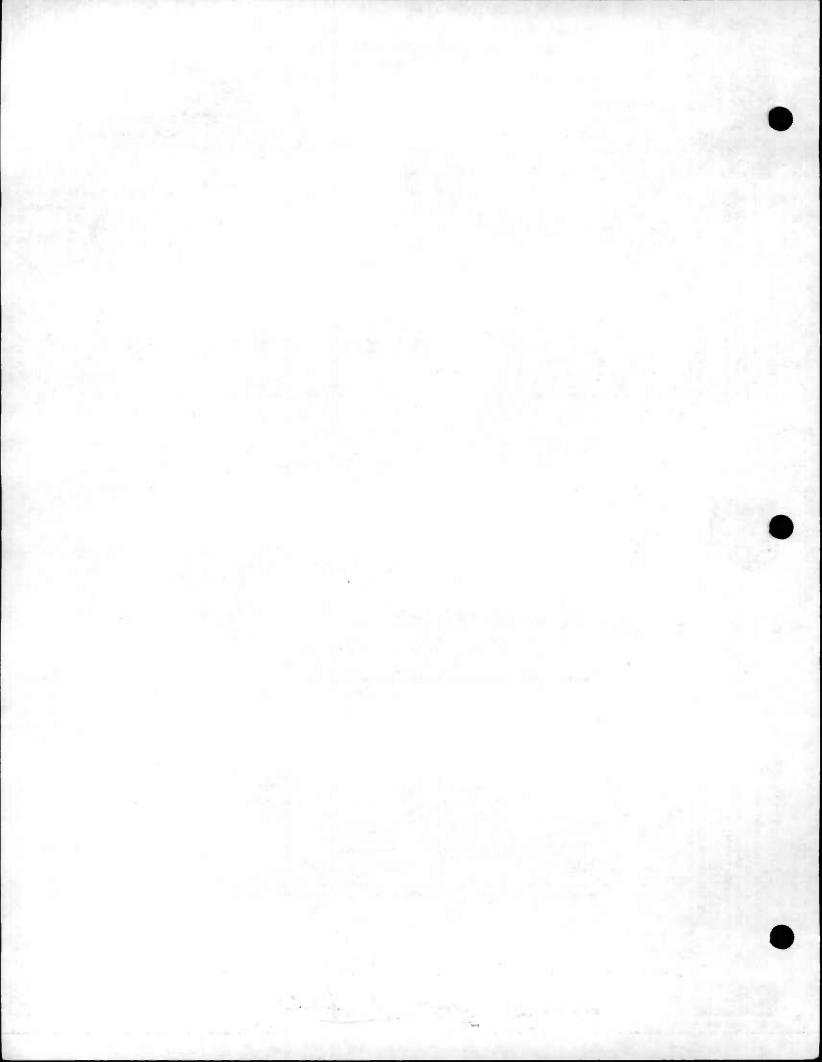
To the Funeral Director: After this completely filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), JOHN T. KOGERS LOCH RAVEN 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

A.

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Hall Dec 19 1999 08:06 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) general 6. Sex 4c. County of Death Examiner hospital Howard county Columbia If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Yrs. 88 328-12-4981 Director 02-26-11 FL. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show 1 Yes 2 No Columbia Director MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 6334 Cedar Lane 21044 USA 'natural', or items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes √2 ☐ No Specify: Specify: Black ★ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Heelth and Mentel Hygien important: if tem 27 is marked other the any injury or other traumatic event, the page. 12th Grade 4yrs. Nurses Aide Nurses Facilities 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Alice Andrew Brown Lowe 19a. Informant's Name/Reletionship (Type, Print) A.D. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40203-1300 West Chestnut Street Louisville, KY 1799 Porter + Son F.H. Inc. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Removal from State Green Meadows Cemetery 12-27-99 Jefferson Co, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 1/17 23a. PartT. Entar the disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examiner lew requires that the death certificate be executed physicien and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last P.O. Box 68760. Physician/Medicai Due to (or as a consequence of). Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 28No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: Be 25. Wes case referred to medicaf examiner? 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Netural 5 Pending deeth. 1 Yes 2 No investigation 2 Accident efter deet! Director: 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or within 24 hours efter To the Funeral Direcompletely filled in b 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34974 of Melita, Mo Dec, 20

State Registrar

DHMH 16 Ray 6/95

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print).

CHARLIMENTA, MD. 8775Cloudleap CT, # 224, Column 1314, MD 21045 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Da **Physician** December Woodberry /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Battimore Baltimore Veterans Administration Medical 5. Social Security Number & Sex 7. Age (In yes, just birthday) Bathmore City Birthplace (State or Foreign Country) **Funeral** 213-36-3406 MM 2DF Yrs. Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1. Yes 2 □ No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UJA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Wildowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "nath any Injury or other traumatic event, the Medical entary/Secondary (0-12) College (1-4or 5+) Mc CORMICK & COMPANY WORKER GRADE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be KOBERT P HENRIETTA WOODBERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 508 EAST 38+HSTREET, BALTIMORE, MD. 21218
Date 20c. Location - City or Town, State ELAINE FRIEND) HUFF 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORI 4 ☐ Donation 5 ☐ Other (Specify) BALTIHORE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME JOSEPH 2140 N. FU H MD. 2121 FULTON AVE. BALTIHORE, 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical NISPASP ten oronan **Examiner** Due to (or as a consequence of) Examiner the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): and physicien Box 68760 certificata be Physician/Medical Due to (or as a consequence of) signed by the attending to be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 □ Probably Unknown 1 ☐ Yes 2 ☐ No by 24b. Were eutopsy findings available prior to 24e. Wes an eutopsy Completed completion of ceuse of death? 212/10 1 ☐ Yes 20 No 1 Yes certificata 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To funaral 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Accident Injury 1 Yes 2 No deeth. i or Attand after deeth Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner es stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and 1856 of certified 29c. License number 29d. Date signed (Month, Day, Year) MO lecember 22 30. Name end aggress of person who completed cause of death (Item 23e) (Type, Print) Greene South Maryland Jean Hou 32. Registrar's Signature State Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



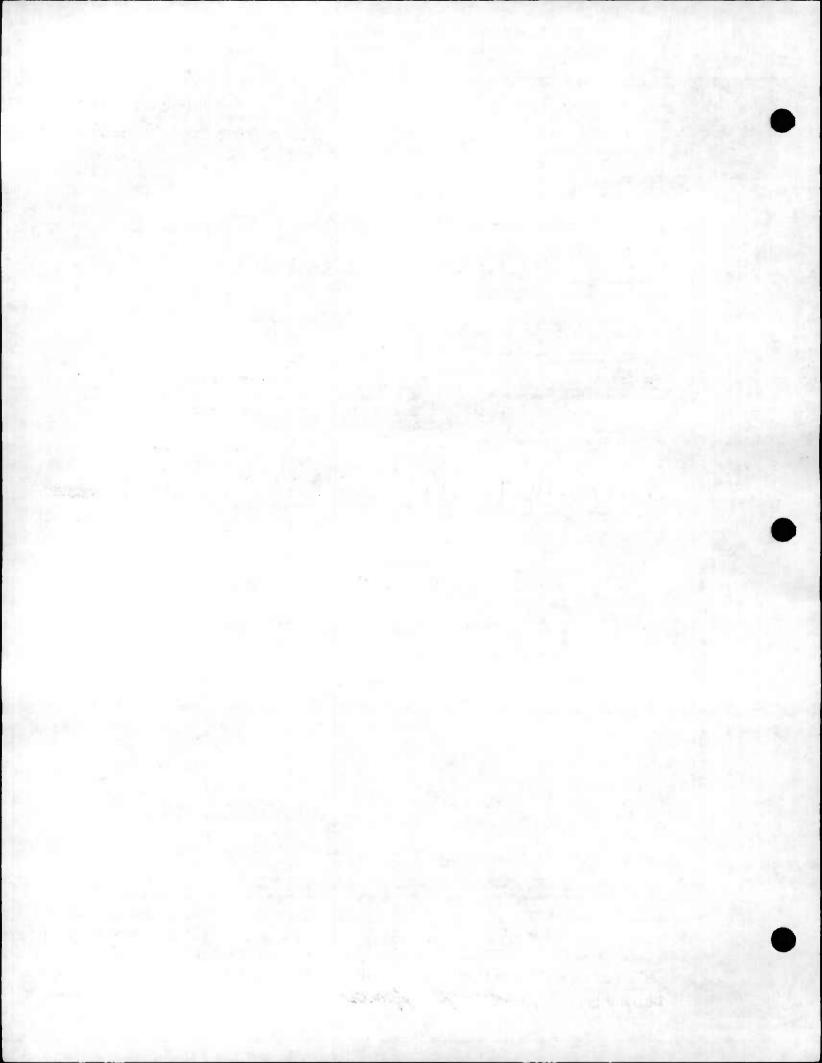
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or 18s-fr	MD Baltimor	e A	rbutus	Zip Code			10g. Citizen of \		
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e de	20a. Method of Disposition		Plece of Disposition (/ cemetery, cremetory of	Verne of or other plea	ce)	Dete	20c. Location -	City or Town, State	
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ORIGINAL



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🔾 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Day **Physician** 928 Bertha Green (AKA Alice Housley) Riember 26,1999 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** CHMURE nder 24 Hrs. 8. Dr Greneral oital paryland 405 8. Dete of Birth (Month, Dey, Year) 08/13/1918 5. Social Sacurity Number 7. Aga (In vis. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2□F 421-26-7759 81 Alabama Director Usual Rasidence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at 1 No 2 No Director Maryland Baltimore 10f Zin Code 10e Street and Number 10g. Citizan of What Country? 645 North Rosedale Street 21216 U.S.A. death \ Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amaricen Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Haatth and Mantal Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Montal Eventual page. Black White atc. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Day Care Provider Caretaker 18. Mothar's Nama (First, Middla, Maidan Sumeme) 17. Fathar's Nama (First, Middle, Last) Be 2 Charles Sanders Elijah Hendricks 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, State, Zip Coda) 645 N. Rosedale St., Baltimore, Maryland 21216
laca of Disposition (Nama of Data 20c. Location - City or Town, Stata Valina Clark / Daughter 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition 1 XBurial 2 Cremetion 3 Ramoval from Stata Mt. Zion Cemetery 01/03/2000 Landsdowne, Maryland 4 Donation 5 Othar (Specify) 21 Signatura of Funarel Service License 22. Name and Addrass of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications the classed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert feilure. List only one cause of enter line. Physician /Medical Immadiata Causa (Final disease or condition resulting in deeth) Examiner Examiner Te The law requires that the death certificeta be executed Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in deeth) Lest and Dua to (or es e consequence of): ettanding physician a for use es the buriel-Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings avallabla prior to complation of causa of daeth? 24e. Was an autopsy performed? Completed cartificete has b 1 🗆 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: director, 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Dey Year) funeral 28d. Dascribe how Injury occurred 27. Mannet of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No death. investigation Director: / 2 Accident 6 Could not be datarminad 28f. Location (Street and Numbar or Rurel Route Number, City or Town, Stete) 3 Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) within 24 hours efter d To the Funeral Direct completaly filled in by 4 - Homicida 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to tha causa(s) end menner es steted. 29a. Cartifian edical (Check only one) 2 Medical Examiner: On the besis of axeminetion end/or investigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifiar to Maryland General Hospital 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

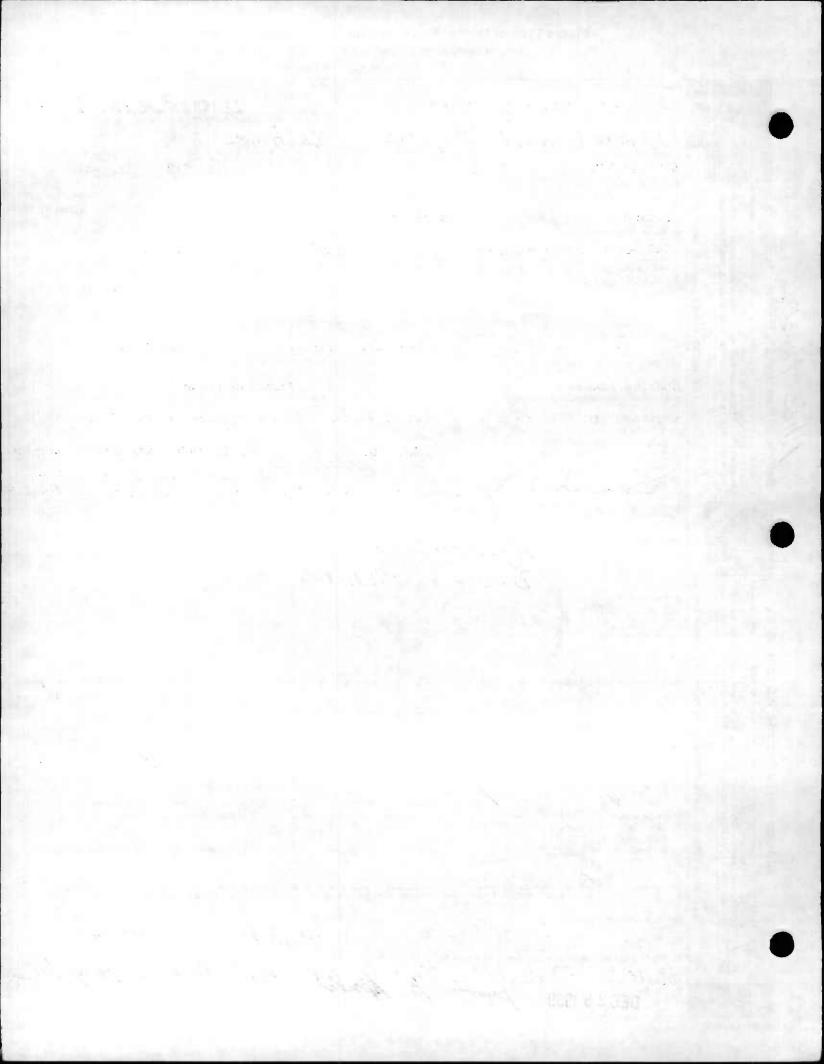
State Registrar

31. Data filed (Month, Day, Y

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician 9:53 A.M. 1999 25 Mary E. Hasselbarth Nacamber /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Hospital Center Kosedala If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 3, 1939 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2以F 60 Yrs. 220-36-4746 Director **Usual Residence of Decedent** 10n State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Baltimore Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be o 4110 Walter Avenue 21236 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ild be filed within 72 hours after di ental Hygiene. Yed other than "natural", or hem Ic event, the Medical Examiner. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Bookkeeper Florist Department of Heath and 2 should be file.
Department of Heath and Mental Hyg.
Important if New 27 is marked other any Injury or other transment other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert C. Brockmeyer Beulah Μ. Downey 19a. Informant's Name/Relationship (Type, Print) [hwband] | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George A. Hasselbarth 4110 Walter Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State SEL 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 12/29/99 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Schimunek Funeral Home, Inc. turt 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Enterococcus Sepsis Weeks Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 計 After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 | Natural 2 | Accident 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 88821 12/92 0 ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar L. Davis,

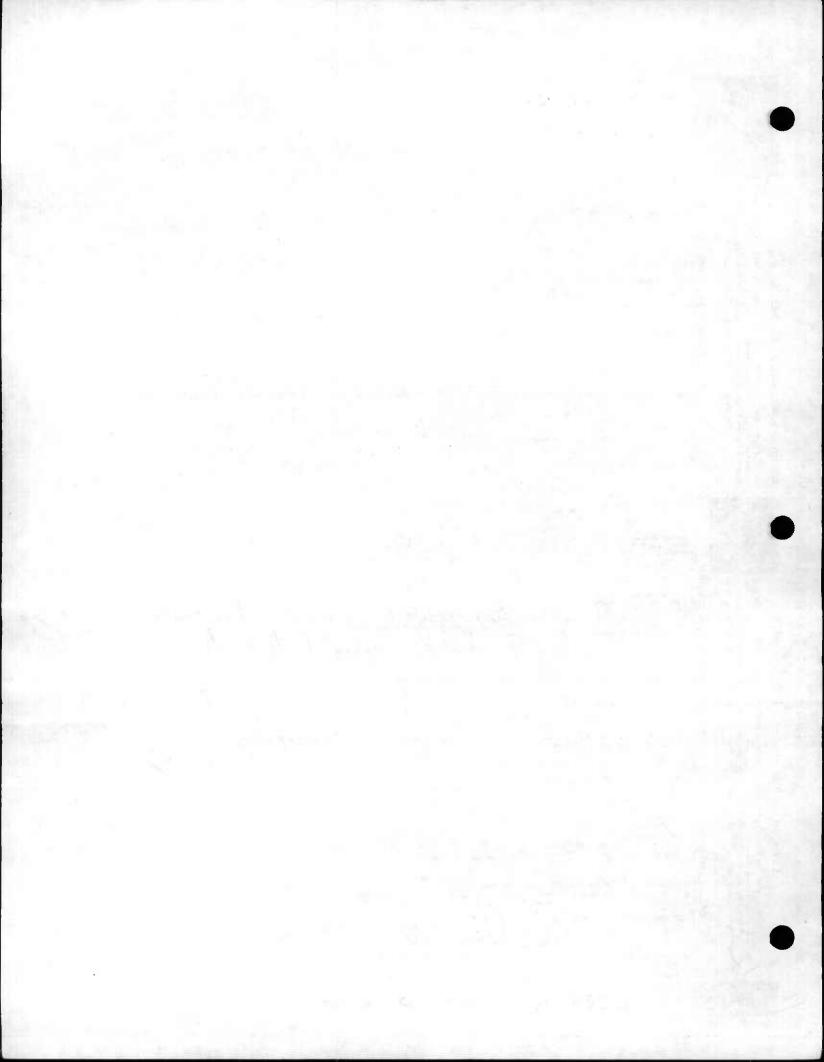
1999

9000 Franklin Square Drive,
32. Registrar's Signature

Baltimore, Maryland 2123'

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical	KATHLEEN D. HAMILT			Dece	mber 27, 1999 1522
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2 44 4			10f. Zip Code	-	10g. Citizen of Whet Country?
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115 hedical	(Specify only highest gra	de completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	e during most of working ed)	Tool value of Deciriosa made say
d 2121 led within hygiene. her than nt. the Me	12th grade	College (1-4or 5+)	Homemaker		Own Home
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M Saga	William M. Hamilto	on (Son)	2140 Nonthri	dge Drive. Bel	Air. MD 21015
of Tage	20a. Method of Disposition		Place of Disposition (Neme of pemetery, cremetory or other p		20c. Location - City or Town, Stete
Baltimore semit. Pages 1. Separtment of He mportant if Nen ny Injury or oth	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Inemover from State	emetery, cremetory or other p 2en Mount Crem		99 Baltimore, Marylan
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	1 Mai	11.			
	23a. Pert1. Enter the disease, or com- shock, or heart failure. List only	plications thet caused the death one cause on each line.	h. Do not enter the mode of d	ring, such es cardiac or respirator	ry errest, Approximate Intervel Between Onset end Death
Physician /Medical	1		- 1		Onset end beauti
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60 be e burie	cause. Enter Underlying Cause (Disease or injury	c. Heman	-hagte >1	100k - Tho	longed I don
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Sio	2 ☐ Accident investigation			Yes 2 No	
IVI Ferder Ferd Ferd	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, offic	28f. Location City or	on (Street and Number or Rural Route Number, Town, State)
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t hour uner uner sky fill	29a. Certifier PS-Certifying Ph	ysician: To the best of my knowliner: On the basis of examinat	wledge, death occurred at the	time, date end place, end due to	the cause(s) end menner es steted. me, date end place, end due to the ceuse(s)
the H	(une)	and manner steted.			
N Tales	29b. Signature and little of certifier	////	29c. Lice	nse number	29d. Date signed (Month, Dey, Year)
	Loge	e Ver		50653	12-28-99
N	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	- 1 - 1/	1 1
10	Kaser Es Sch	noddler - 211	Z Felair	Load, talls	You laurend
State	31. Date filed (Month, Day, Year) DEC 2 9 199	32. Registrar's Signe	ture & Some	1	
State		39 Deneva			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Siegel Ray Hager December 23 1999 10:12 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner N/A Baltimore Harbor Hospital Center 5. Sociel Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days 1XM 2□ F 69 Yrs. 215 28 8520 Director May 7, 1930 West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f shorter was be notified at 1 NYes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after daath with 21225 U.S. 4013 - 2nd Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1948 If Yes, Give Yeer or Detes: 1950 Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Stetus Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Apt Elementery/Secondery (0-12) College (1-4or 5+) Christ Church Harbor Maintenance Engineer 12th permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any injury or other traumatic event pages. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Liza Nichols Robert Lee Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4013 - 2nd Street Baltimore, Maryland 21225 Norma J. Hager 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlet 2 Cremetion 3 Removel from State 12/27/99 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licansee 22. Name end Address of Fecility Gonce Funeral Home P.A. Baltimore, Md. 21225 4001 Ritchie Highway mamurouser 23a. Rart1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 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(Check only one) 2 Medical On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted. \$ 29b. Signature end title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 16 Rsv 6/95

615 Hammonds Lane

D 30137

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32. Rendirar s Signature

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Campo M.D. 229 1999 32

Daniel

99

Baltimore, Maryland 21225

Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 24 1999 **Physician** JOHNSON OUI /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner MAKY LAND HOSPITAL MORE UNIVERSI a If Under 1 Yea 8. Data of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 69 Months Deys Hours 1 M 2 F 250-42-4554 Usual Residence of Decedent SOUTH CAROLINA Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Funeral Director MARYLAND 288-10a. Sireet and Number Og. Citizen of What Country? 6 death with 21223 or itema 23a BALTIMORE STREE 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marilal Slatus filed within 72 hours after 1 Yas 2 No If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify ò 3 ☐ Widowed 4 ☒ Divorced naturai Be Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working tite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ABORER 4NKNOWN ONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filk Department of Health and Mentel Hy Important: If Nem 27 is marked oth any injury or other traumatic event PARS. BURD JERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) MOSCOE JOHNSON (BROTHER) 2004 W. FAYETTE STREET, BALTIHORE, MD, 2/223 e of Data 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1⊠Burial 2 □ Cremation 3 □ Ramoval from State LANSDOWNE, MD 4 ☐ Donation 5 ☐ Other (Specify) ZIO METERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. BALTIMORE, MD. 2/2 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) PULMONARY HEMORRHAGE /Medical Examiner Physician/Medical Examiner UNG CANCER The law requiras that the deeth certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl Due to (or as a consequence of): Box 68760. ORTIC STENOSIS Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 Yee 2 □ No 3 Probably 4 Unknown 9 Division of Vital Records, à 9 Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? page 2 should completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate Physician: 25. Was case referred to medical examinar? Be 26. Placa of Death (Check only one) Hospitai: 1 Xinpatieni Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) funerel 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Panding investigation Attending s efter deeth. ii Director: Aft ed in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 6 To the Hospital or within 24 hours of To the Funeral D 1 Cartifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 74 30. Name and address of person who complete touse of death (item 23a) (Type, Print)

Registrar

State

22 South Greene St BALTIMORE MY

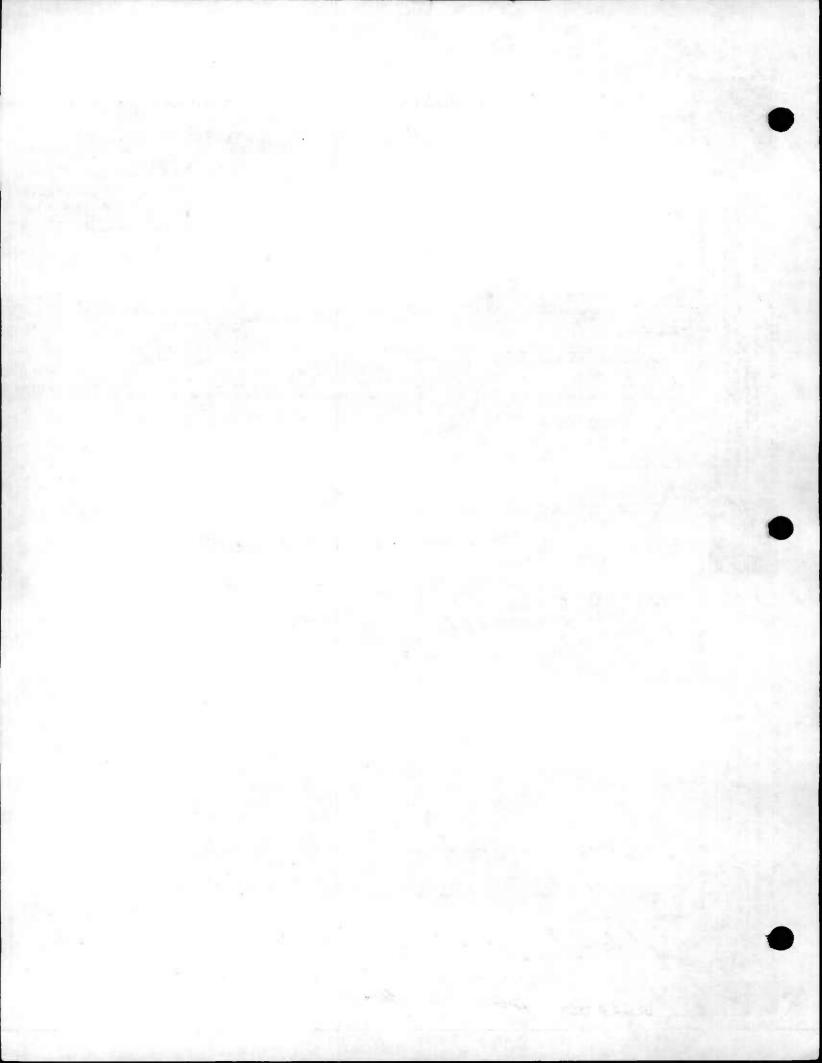
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32. Registrar's Signature

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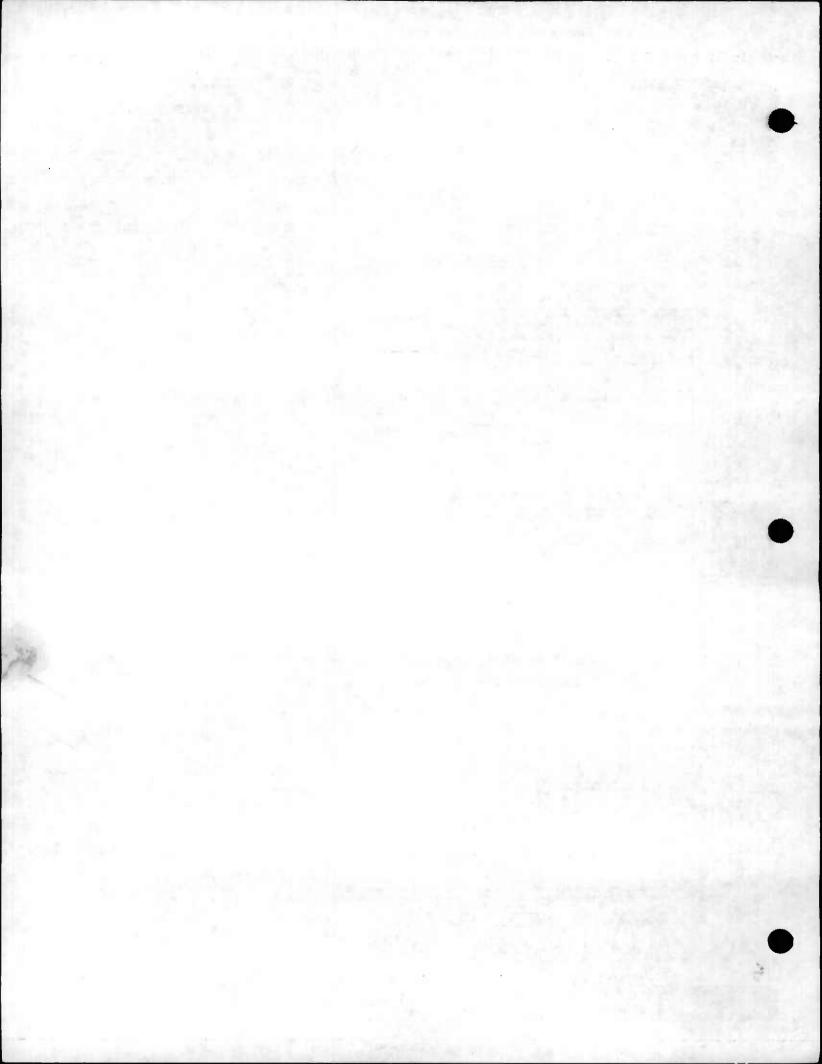
State Registrar

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32. Registrar's Signature

tane 111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OIN DEC /Medical 4b. City, Jown, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner JANE orien 8. Date of Birm (Month, Dur. 3 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2 F -9123 -20 88 107 Yrs. Director Usual Residence of Decedent 10c. City, Toyn or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Haelih end Mentel Hyglans. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinal must be notified at PAGE. 1 ☐ Yes 2 X No Director 10f. Zip Code vak 10g. Citizen of What Country? S Funeral 12. Wes Decedent Evar in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 7
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Merried 2 □ Merried Baitimore, Maryland 21215-0020 1□ Yes 204 No Specify Specify: ack þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Şecondary (0-12) OME 10+17 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be STEVENS 13170 31770. 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Columbia, MD Mildred 7080 CraddleRock Dayghter Way SUNOF 20a. Method of Disposition

1 Surial 2 Semetion 3 Removel from State
4 Donation 5 Other (Specify) 20b. Plece of Disposition (Name of cametery, crematory or other plece) Date 20c. Location; City or Town, Stata KNOGE 12-3199 POPITWODESS 21. Signeture of Feberal S 22. Name and Address of Facility Gary P. March FUNERAL Pass Baltimore MD 2/229 Fredhillon to comp cations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Intervel Between Onset and Death Physician /Medical disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine Mellitus)iahetes ettending physician and ifor use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Peripheral Vascular P.O. Box 68760, an/Medical Due to (or es a consequence of): i signed by the et id be deteched fo Physici Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 188 1 Yes 2 No 1 ☐ Yes 2 B No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2, No 1 Inpatient 2 ER/Outpatient 3 DOA this funarai 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Aftert Certification: Attending 5 Pending investigation 1 Neturat To the Hospital or Attending within 24 hours efter death.
To the Funeral Director; After completely filled in by the fun 1 | Yes 2 | No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide 16 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, data and place, and due to the cause(s) end mennar es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier obit Dower mo D0055437 Dec. 27, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Bower 3460 Ellicott Centy Dr. #103 Ellicott City, MD 21043 mo 31. Dete filed (Month, Day, Year) 32/Registrar's Signeture State DEC 29 Registrar

ORIGINAL

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IRVIN FRANCIS SACKSON, SE **Physician** 8:00 DEC. 22 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GARDERS NUrsing Home HARAORO BAHHORE If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) **Euneral** Months 21703 3867 M 2□ F Days May 27, 1913 Mary lons Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ehow. 10d. Inside City Limits BALHHORE Yarylow JESTes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N. BENTAlou StrEET 5 21216 USA 238 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 25 No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 'natural', or items 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify Black If Yas, Give Year or Dates: Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working title. DO I/OT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MARYLAND SHIPBULONG al Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 4aintenence Worker grack 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important; if Nem 27 is marked ofthe any Injury or other traumatic avent BASE. Be H. Jackson Willian Evans JOHN 19a. Informant's Name/Rejationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRUID F. Jackson 1727 N. BENTALOU STREET Baltining, Sed 21216 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State HRBUTUS, Marylows MEMORAL for le 4 ☐ Donation 5 ☐ Other (Specify) ALMBUTUS 22. Name and Address of Facility CHATMAN 1 5240 REISTERSTOWN RUSE HATMAN - HARRIS FERENCE Hime 21. Signature of Funeral Service Licensee lery Jan BALTIMOTE, Marylons 23a. Part 2 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Heart- Failure Congestive Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner physicien and the burial-transit Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Box 68760. 8 Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dialritis Mallitus Records, 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 21 No 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No edical Certification: To this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending investigation 1 DNatural death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 4 Homicide To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated. 29b Signature and Ittle of certifier 29c. License number 29d. Data signed (Month, Day, Year)

Registrar

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State

31. Data filed (Month, Day, Year) DEC 2 9 1999

TARICI MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3400 32. Registrar's Signature

Erdman ave Baltimore, Md. 21213

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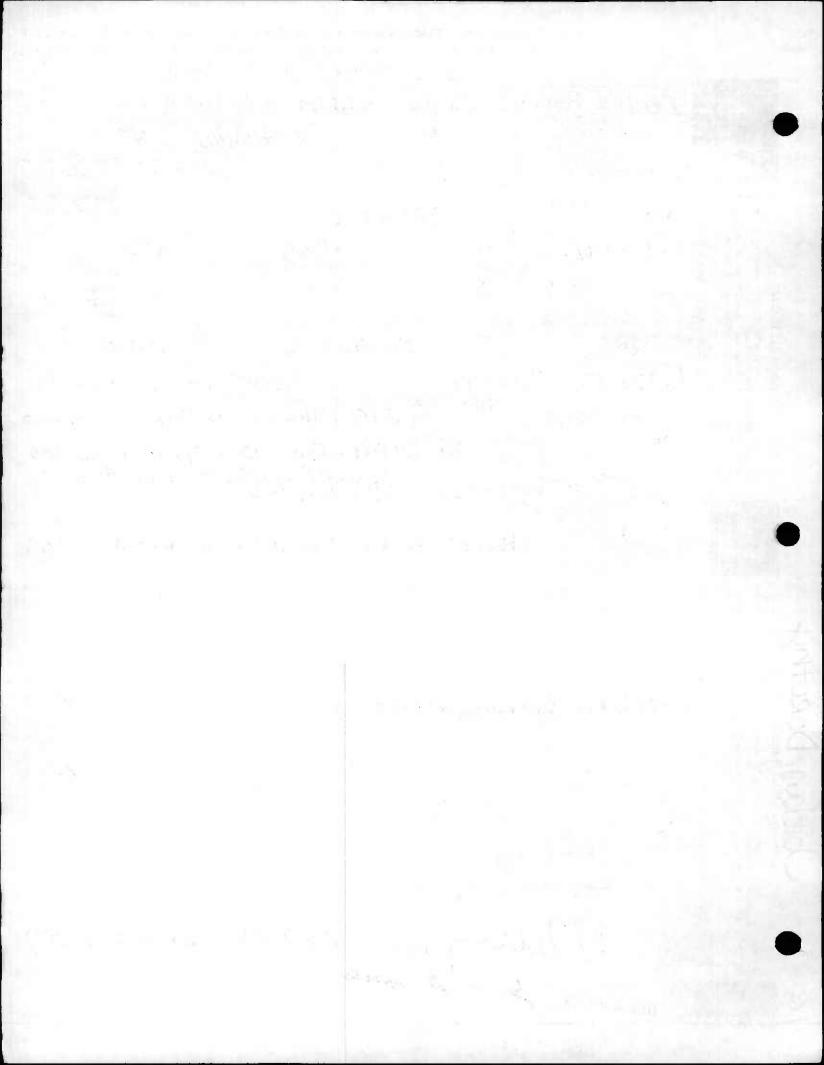
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40704 Certificate of Death Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death DECEMBER 22, 1999 **Physician** BEATRICE JORDAY 6:02 PM /Medical 4c. County of Death 4e. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daeth **Examiner** ST AGNES HOSPITAL 900 CATON AVENUE 7. Aga (In yrs. last birthday) If Under 24 Hrs 5. Social Sacurity Number If Under 1 Yaer Birthplaca (Stata or Foreign Country) 10 M 20 F **Funeral** Months Days 238-40-2358 Usual Rasidance of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at lymore 1 Yas 2 No Director 10f. Zip Code 10g. Citizan of What Country? Funeral 12. Was Decedeni Ever in U,S. Armed Forcasi 1 ☐ Yas 2 Û No If Yas, Giva Yaar or Dates: Was Dacedant of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amaricen Indien, Black, Whita, atc. filed within 72 hours after 1 ☐ Naver Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 Mer. 1□Yes 2No Spacify: ģ 3 Widowad 4 □ Divorced Dimercica Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life, DO NOT usa retired) 15. Decedant's Educetion (Specify only highast grada completed) 16b. Kind of Businass/Industry and 2 should be filed within each and Mental Hygiene. n 27 is marked other than Elamantary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldari Sumama) Be ganna 19b. Mailing Addrass (Street and Number of Rural Route Number, City or Town, Stata, Zip Code) 19a Informant's Name/Balationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any Injury or other trau once. oldner Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place ourial 2 ☐ Cremation 3 Ramoval from Stata ansdowne, mo 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter tha disease, or complications that causad the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batwaan Onset and Death **Physician** tre Cardiordicular Dilease Immadiata Cause (Finel diseasa or condition resulting in daath) /Medical **Examiner** Dua to (or as a consequence of): Examiner ettending physician and for use es the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated avents Due to (or es a consaquance of): Physician/Medical Dua to (or as a consequence of): rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy parformad? hes 2 No certificate 1 ☐ Yas No 1 ☐ Yas To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was casa rafarrad to medical examinar? 26. Place of Death (Check only ona) 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 2 1AYas 2□ No 27. Manner of Death 1 Natural 2 Accidant Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Describe how injury occurred 5 Panding investigation 1 Yas Divisi(6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, afc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida The certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and manner as stated.

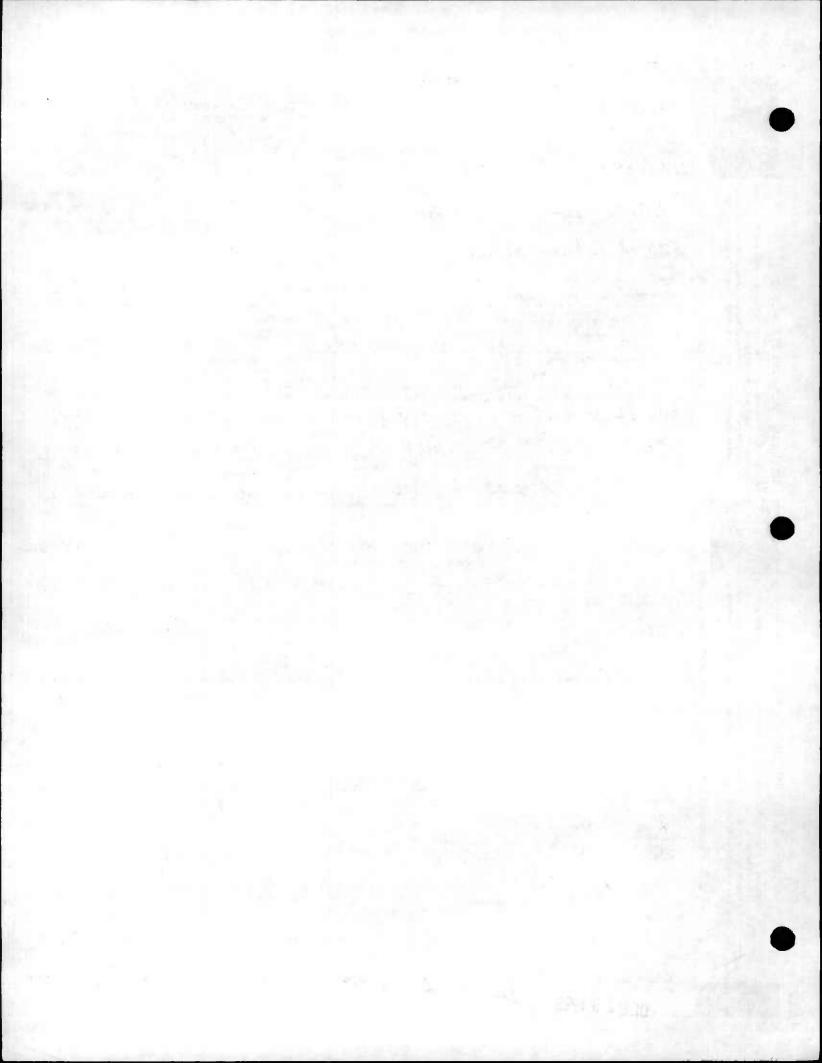
I madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature end titla of certifia 29c. License number 29d. Data signed (Month, Day, Year) 027315 pleted causa of death (flem 23a) (Type, Print) 30. Nama and address of person who of Sporks 52 Bedistar's Signature 31. Data filad (Month, Day, Year) State DEC 2 9 1999 Registrar

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	1. Decedent's Neme (First, Middle, La	st) James E. Gilbe	rt		2. Date of De	ath		3. Time of Death
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	James	Dovis		Mary	L. Gi	Iberl		
	19e. Informent's Neme/Relationship (Type, Print) Mother	19b. Mailing Address (Stre	et and Number of Rura	I Route Numb	er, City or Town,	State, Zip C	ode)
	Mary L. Gilbe.	T	520 N. Gil	mor street	T BALL	Imove, w	10,21	223
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	snock, or near failure. List only	one cause on eech line.						ntervel Between Onset and Deeth
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	disease or condition resulting In deeth)	a Diffuse	Caranoma	160115			13	MONTHS
		Due to (or	as a consequence of):				1,	
		b. Cancer o	of the	DUNUTEUN			16	Months
	Sequentially list conditions,		as a consequence of):			9 10 9		
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury						l l	
	triat initieted events	C. Due to for a	as e consequence of):					
	resulting in death) Last	200 10 (0)	s samoquorios orj.					
		d						
	Part II. Other significant conditions co	ontributing to death but not result	ting in the underlying cause	given in Pert I.	23b. Did	tobacco use cor	ntribute to ti	he cause of death?
					10	Yes 2 No	3 Probei	bly 400 Unknown
								,
I						en eutopsy	24b. Were	autopsy findings
١						rmed?	availa	able prior to pletion of cause leth?
							of de	eth?
					10	Yes 2 No	10	Yes 200 No
	25. Wes case referred to medical			26. Place of Deeth	(Check only o	one)		
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 E	R/Outpatient 3 DOA	Other: 4 Nursing Hor			er (Specify)	
	27. Menner of Death		28b. Time of 28c. in			how injury occurr		
	1 Naturel 5 Pending investigation			Vork? ☐ Yes 2 ☐ No			70	
	3 ☐ Suicide 6 ☐ Could not be				of Leaster 1	Ctroot and Alice t	a. a. D 1 5	Pouto Miret
1	4 ☐ Homicide determined	28e. Plece of Injury - At horr building, etc. (Specify)	ne, rerm, street, fectory, offic	20	City or Tol	Street end Numbern, Stete)	er or Hural F	noute Number,
l	29a. Certifier Certifying Phy	ysician: To the best of my knowl	ledge, death occurred at the	time, date end pleca, e	end due to the	ceuse(s) and ma	nner es stat	ed.
1	one) 2 Medicai Exam	niner: On the basis of examinetic and menner stated.	on end/or investigation, in m	y opinion, deeth occurre	ed et the time,	date end plece, e	end due to th	ne cause(s)
ľ	29b. Signature and title of certifier		29c. Lice	ense number	1/2	29d. Date signed	d (Month, Da	ay, Year)
	1 000	00 -	0	01 221		101	1201	1000
1	Milens	MID		8634		12/	2811	1779
	30. Name and address of person who o	completed cause of deeth (Item 2	23a) (Type, Print)				5.11	1
	ilictor M.	Moyo	23a) (Type, Print) JOHNSHOP NAME	& Hospital	600 Nn	eth water	St. BAIT	MD 21307
Í	31. Date filed (Month, Dey, Year)	2. Registrat's Signatu	6 pposts	1 1110	7 - 110	1,000,11,000		
	DEC 2 9 1999							
L	DLO W G 100	/1						



DHMH 16 Rev 6/95

State

Registrar

6935 DONACHIE Rd Apt G, BALTIMOR E-MA 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 2 9 1999

32. Registrar's Signature

GILBERT ZOGHBI,

31. Data filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Physician DECEMBER 25, 1999 7:15AM Н. George Kinlein /Medical 4a Fsclity Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Desth Examiner Stella Maris Hospice at Mercy Hospital Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, May 29, May 29, 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) Maryland **Funeral** 1 M 2□F 1925 Director 219-10-1751 Usual Rasidance of Decedant within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or farms 23a or 28a-f show treumatic event, the Medical Examinar must be notified at XX Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1534 Baldwin Street 21211 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas XIX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: Specify: White ff Yas, Giva Yaar or Datas: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Meali phise. Elamantary/Secondary (0-12) Collega (1-4or 5+) Loaded Railway Cars Railway Express 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be George H. Kinlein Emma Keys 19s. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1118 Weldon Avenue, Baltimore, Maryland 21211
Data | 20c. Location - City or Town, State George H. Kinlein, Jr. Son 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1XX Burial 2 Cremation 3 Ramoval from Stata 5 Other (Specify) Moreland Memorial Park |12/29/99 Parkville, Maryland 4 Donetion 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Eyer tha diseasa, or complications that caused the death. Do not enter the mode of dying, shock, defect fellura. List only one cause on each line. Road, Baltimore Maryland Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Corcinona of The Nack Squanovs Examiner Dua to (or as s consequence of): Physician/Medical Examiner physician and s the burial-transit Sequantially list conditions, if sny, laading to immadiate causa. Entar Undarlying Causa (Disease or injury that initiated events rasulting in death) Lsst a Hospital or Attending Physicien: The law requires that the death certificate be executed to the standard.
24 hours after death.
Pureral Director: After this certificate has been signed by the attending physician and lately filled in by the funeral director, page 2 should be detached for use as the burial-tran Dua to (or as a consequence of): Box 68760, Dua to (or as a consequence of) P.O. | 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wara eutopsy findings available prior to complation of cause of death? Completed 24a. Wes sn sutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was casa refarred to medical axaminar? 26. Place of Desth (Check only one) Other: 4 | Nursing Homa 5 | Residence & Sothar (Specify) HOSpice 1 Yas 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) Mennar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending invastigation Neturel 1 Yas 2 No 2 Accident 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signafura and fitla of certifian 29c. License number 29d. Data signed (Month, Day, Year) un MD 30. Name and addrass of person impleted causa of death (Item 23a) (Type, Print

DHMH 16 Rev 6/95

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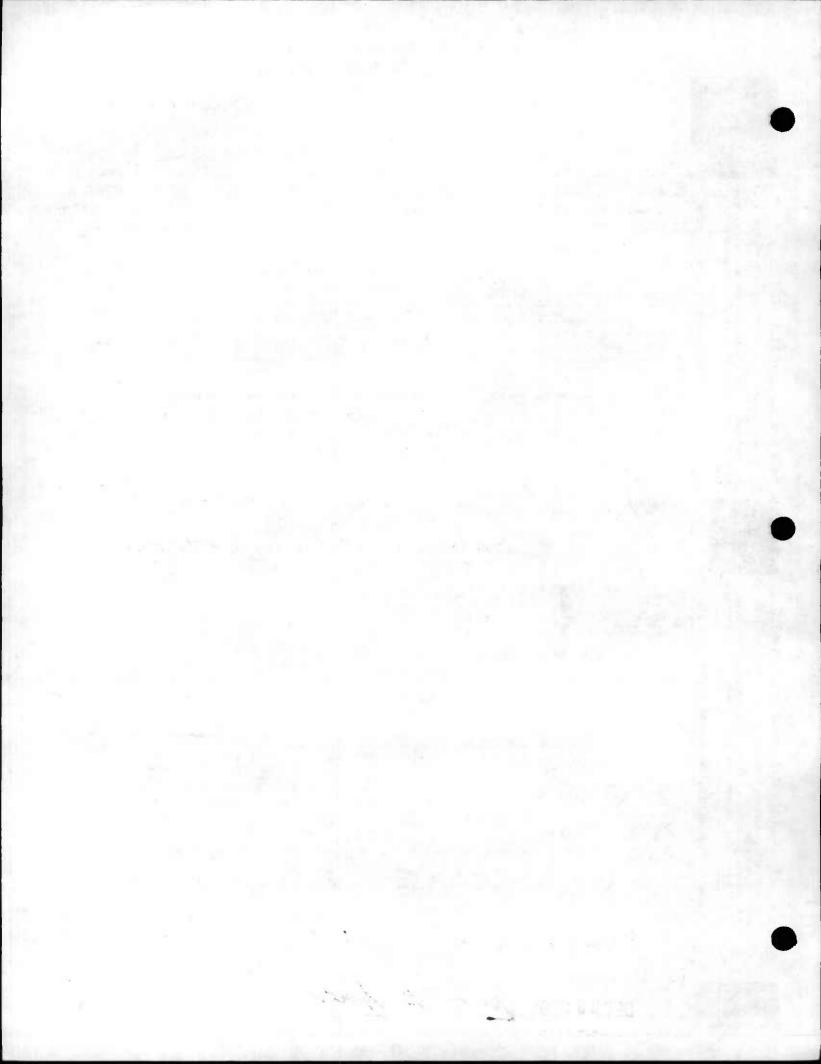
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Data filed (Month, Day, Year)

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32. Registrar's Signatura

School



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death Vas **Physician** 9 AM Inez December 24, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 204 Midpines Court Apt. 2B Owings Mills Baltimore | UWITINGS | ITUnder 1 Year | ITUnder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplece (State or Foreign Country) | April 24, 1906 | South Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2/C/F 93 Yrs 242-01-8469 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits I be filed within 72 hours after deeth with the Marylar ntal Hygiene. ed other than "natural", or Itema 23a or 28e-f ahow avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Midpines Court Apt 2B 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saitimore, Maryland 21215-0020 1 □ Yes XIX No Specify: Specify: White þ XIX Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cotton Mill Assembly Worker Textile Mills 9 pemit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked oths any Injury or other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) B Henry Stein Dora Ellen Peele 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 21117 Paulette Alexander 204 Midpines Court Apt 2B Owings Mills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Donetion 5 Other (Specify) 12/29/99 Pikesville, Maryland 5 ☐ Other (Specify) uneral Service License 22. Neme and Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road Baltimore Maryland anter the mode of dying, such as cardiac or respiratory arrest, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or have failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 8 week Examiner Examiner physician and a the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Box 68760 2 Physician/Medical Due to (or as e consequence of): 8 P.O. 1 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of cause of death? 1 Tes 2 3 No 1 ☐ Yes 2 ☐ No certificata or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun-1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 112 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated. Medical 29a. Certifier

Division of Vital

State Registrar

(Check only one)

29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

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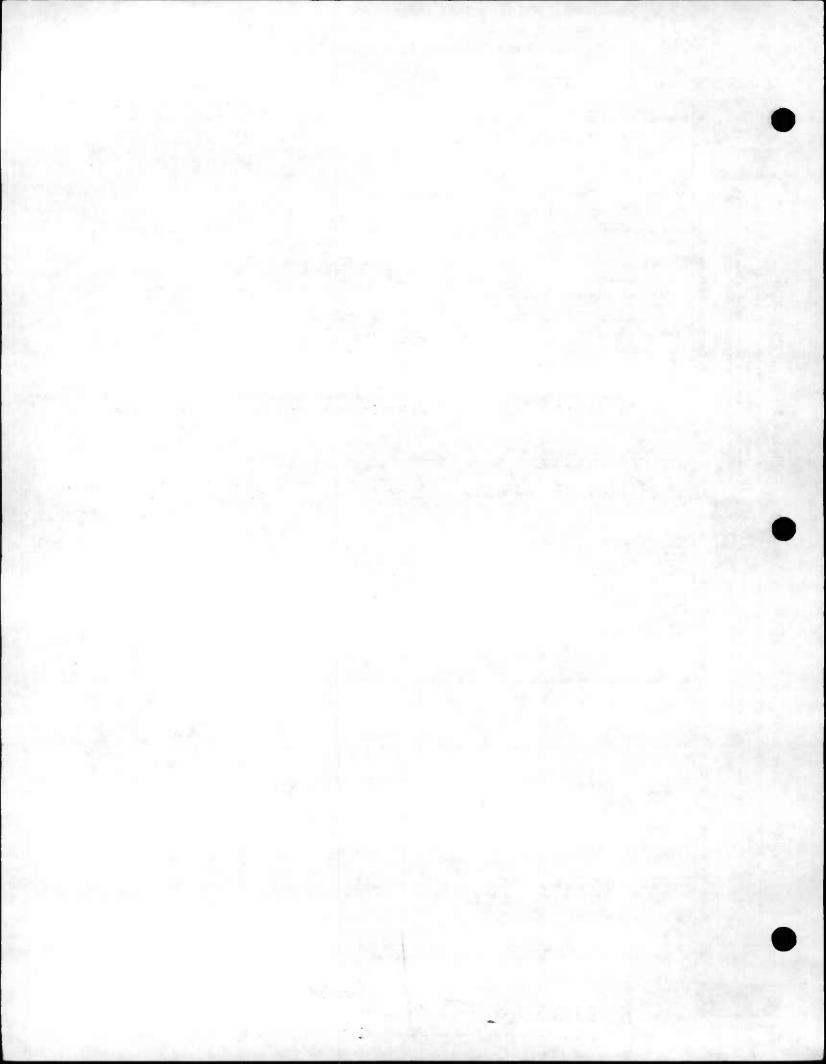
NE

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

000 32. Registrar's Signature

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)



Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dey Month **Physician** NANCY RUTH HARRIETT KERN 27 1999 9:27 BM December /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rosedale 15A If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) MAY 26, 1941 SqUARE BAITIMORE FRANKlin Center HOSPILAL 5. Social Security Number 217-38-9921 If Under 1 Year Birthplaca (State or Foreign Country) MARYLAND 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days 1□ M 25 F 58 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic exceptions. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD ¥ Yas 2 No N/A Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 DRUID HILL AVENUE 21201 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Datas: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or Notl Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married 1 Yas 2X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ♥ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) HOUSEWIFE DOMESTIC 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maiden Surname) Be THOMAS WAYLAND FRANCES KEITH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) JEANETTE KUNGIS - DAUGHTER 1547 PATUXENT MANOR RD. DAVIDSOVILLE, MD 21035 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Steta 1 Surial 2 Cramation 3 Ramoval Irom State 4 Donation 5 Other (Specify) LAKEMONT MEMORIAL GARDENS 12/31/99 DAVIDSONVILLE, MD 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Fecility CHARLES S. ZEILER & SUN, 11VC. 6224 FASTERN AVENUE BALTIMORE, MD 21224 enter the mode of dying, such as cardiac or raspiratory arrest, Intervet Between Onset and Death 23a. Part I. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrestables, or pear tailure. List only one cause on each line. **Physician** Immediata Causa (Finel disease or condition resulting in daath) /Medical a. Infarction of SMALL INTESTINE, MULTIFOCAL 12 DAYS Examiner Dua to (or as a consequence of): Examiner Abdominal Severe WALL inding physician and use as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseesa or injury that initieted evants rasulting in death) Last Dua to (or es a consequence of): c. GASTROINTESTINAL HEMORRHAGE of STOMACH Dua to (or as a consequence of): AND SMALL INTESTINE Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown g page 2 should be 24b. Were eutopsy lindings evailable prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 Yes 2□No 25. Was casa ralarred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 1 Denatural 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one)

or Attanding Physician: Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vitai

VANCY

29b. Signature and title of certife

31. Data filed (Month, Day, Year)
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DRI SEAN

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32. Registrar's Signetura

30. Name end eddrass of person who complated causa of death (Item 23a) (Type, Print)

BerenholTz

Registrar

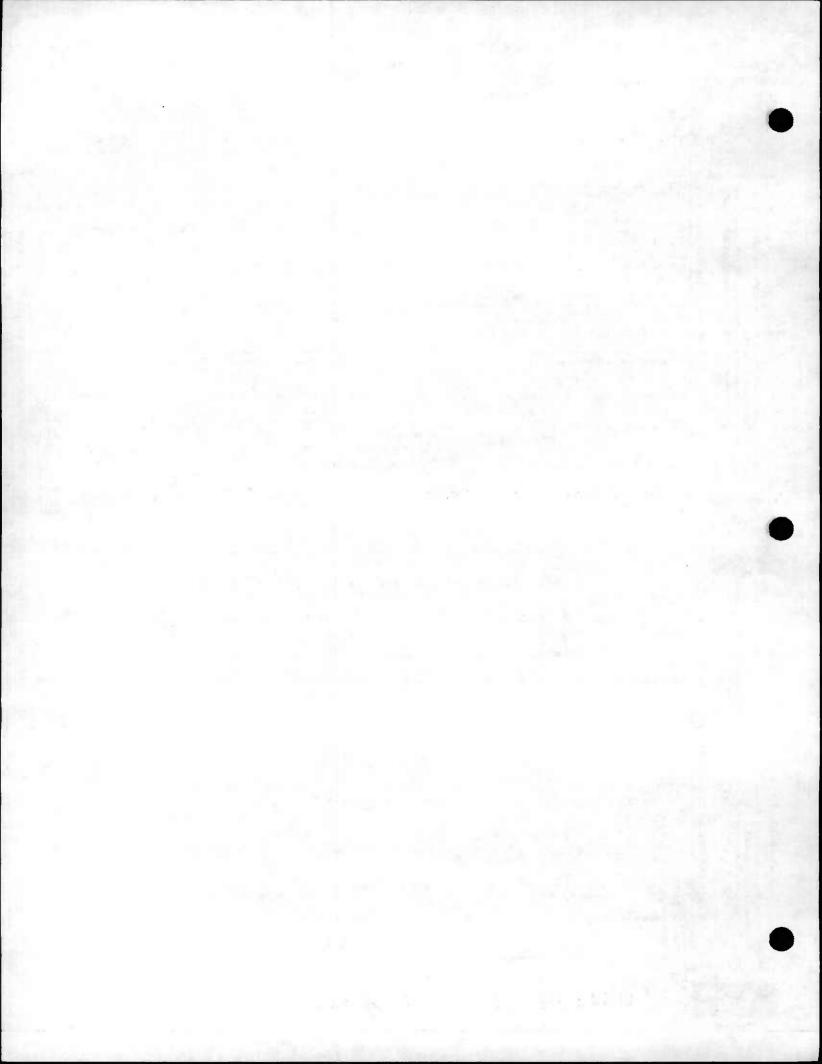
DHMH 16 Rev 6/95

29c. License number

29d. Data signed (Month, Day, Year)

Square DR. BATTIMORE MARYLAND 21237

DECEMBER 27, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Dev Month **Physician** 5 4b. City, Town, or Location of Death 4c. Count 1999 /Medical 4e Facility Name (If not institution, give street end number) 4c. County of Dee Examiner more ohrus VOUS PVT a hes 05 N/AIf Under 24 Hrs. 5. Sociel Security Number Year 8. Dete of Birth (Month, Day, Year) Sept. 15, 1943 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Hours 1 M 2 F Yrs. Director 189-34-8562 56 Pennsylvania Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or ferm 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Columbia Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 Barber Street 17512 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus permit. Pages 1 and 2 should be filled within 72 hours effect begartment of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or hen any Injury or other traumatic event, the process. Black, White, etc. 1 Never Married 2N Merried 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White. Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Colonial Metals Accountant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert H. Lehman. Sr. Dolores Mendenhall 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Raymond E. Kitch, Jr. (Husband) | 820 Barber St., Columbia, Pennsylvania 17512 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holy Trinity Catholic Cem. 12/29/99 Columbia, Pennsylvania 22. Name and Address of Facility. Clyde W. Kraft Funeral Home Inc. 21. Signature of Funeral Service Licensee When 519 Walnut Street, Columbia, Pennsylvania 17512 23a. Port1. Enter the disees of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. I st only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical tailure 4 hours epatic Examiner Due to (or es e consequence of): Examiner 10 day 5 ious attending physicien and for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of) Box 68760. mmuno Supression Physician/Medical thet initiated events resulting in death) Last Due to (or es a consequence of): 4 day s Bone ransplan Marrow logous 0 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings aveilable prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 200 No certificate 1 Yes 1 Yes 2 No Division of Vital al or Attending Physician: The safter death. I Director: After this certificate of in by the funeral director, pe 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Oves 2 No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours af the Funeral DI npletaly filled in Hospital 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

State Registrar

31. Dete filed (Month, Day, Year) DEC 29

Jose

h.

29b. Signeture end title of certifier

Valladares 32. Registrer's Signature

> H.O.

adaust

30. Name end eddress of person who completed tause of death (Item 23a) (Type, Print)

M.O. Johns Hopkins Hospital, 600 N. Wolfe St., Balto, Md.

29c. License number

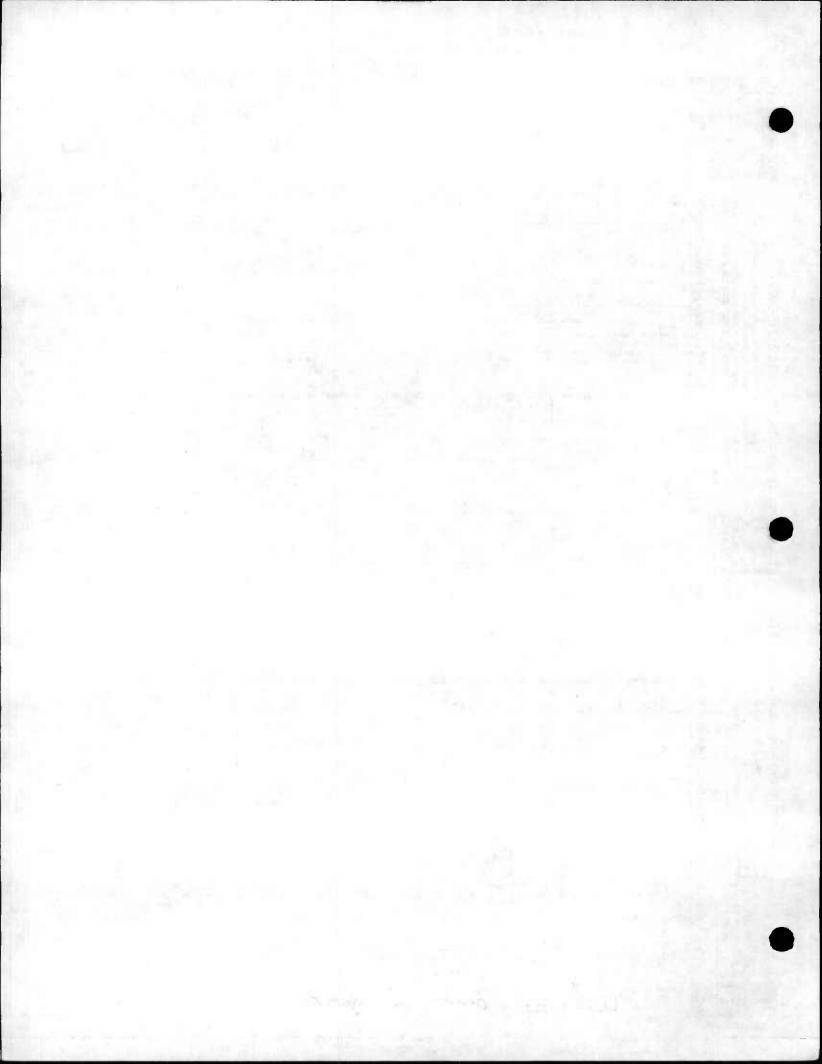
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29d. Date signed (Month, Day, Year)

December 24, 1999

DHMH 16 Rev 6/95

To the To the Comple



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jerzy Kajetanski December 1999 8.50am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Say 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 □ F Days 187-26-0749 86 Yrs. Nov. 8, 1913 Director Russia Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or Nerna 23a or 28a-f show oficial Examiner must be polified at 1 Yas XX No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10405 May Wind Court 21044 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White à 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) (Giva kind of work dona during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) Artist/Screen Cartoonist Paramount Pictures Years permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If Item 27 is marked othe any injury or other traumatic event, bridge. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Edmund Kajetanski Amelia Teobald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Eva B. Skrenta Columbia, MD 21044
Data 20c. Location - City or Town, State 10405 May Wind Court 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data Burial 2 Cremation 3 Removal from Stata 4 □ Donation 5 □ Othar (Spacify) Meadowridge Memorial Park 12/30/99 Elkridge, Maryland ture of Fineral Service Licensee 22. Name and Address of Facility 21. Sign Witzke Funeral Home, Inc. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. MAKwany 21045
Approximate Interval Between Onset and Death 23a. Part1. **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Myocardial Infarction Examiner Two Days Due to (or as a consequence of): Examiner Coronary Artery Disease Years. physician and s the burial-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypertension Years. Physician/Medical Due to (or as a consequence of): as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown been signed be det Stroke. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 XNo 1 ☐ Yes 2 ☑ No director Be 25. Was casa refarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 XNatural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

that the death certificate be executed Box 68760 P.O. Records, Division of Vital or Attending Physician:

attending

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certificate

after death. Director: Aft

Baltimore, Maryland 21215-0020

se filed within 7 all Hygiene.

State Registrar

DHMH 16 Rev 6/95

edical

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 9055 Chevrolet Drive, #100, Ellicott City, MD 21042. N B Vellanki, MD; 2 9 1999

32. Registrar's Signatura

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and mannar as stated.

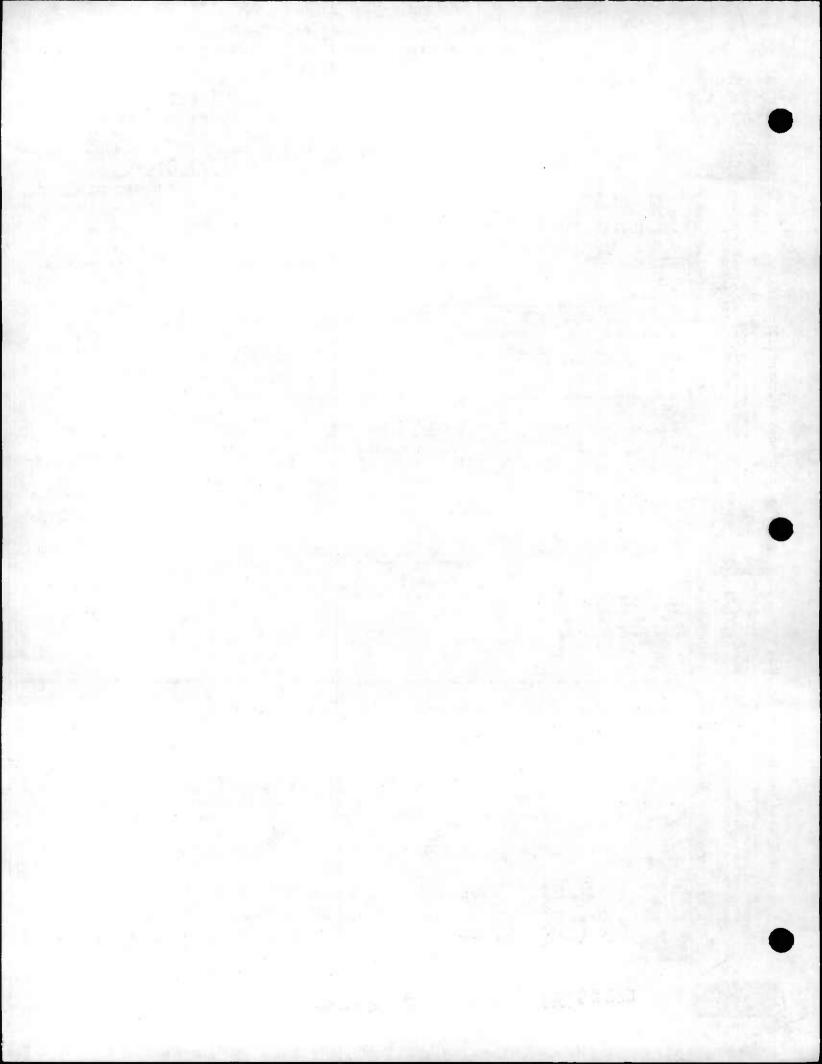
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 30469.

29d. Date signed (Month, Day, Year)

December 27 1999.



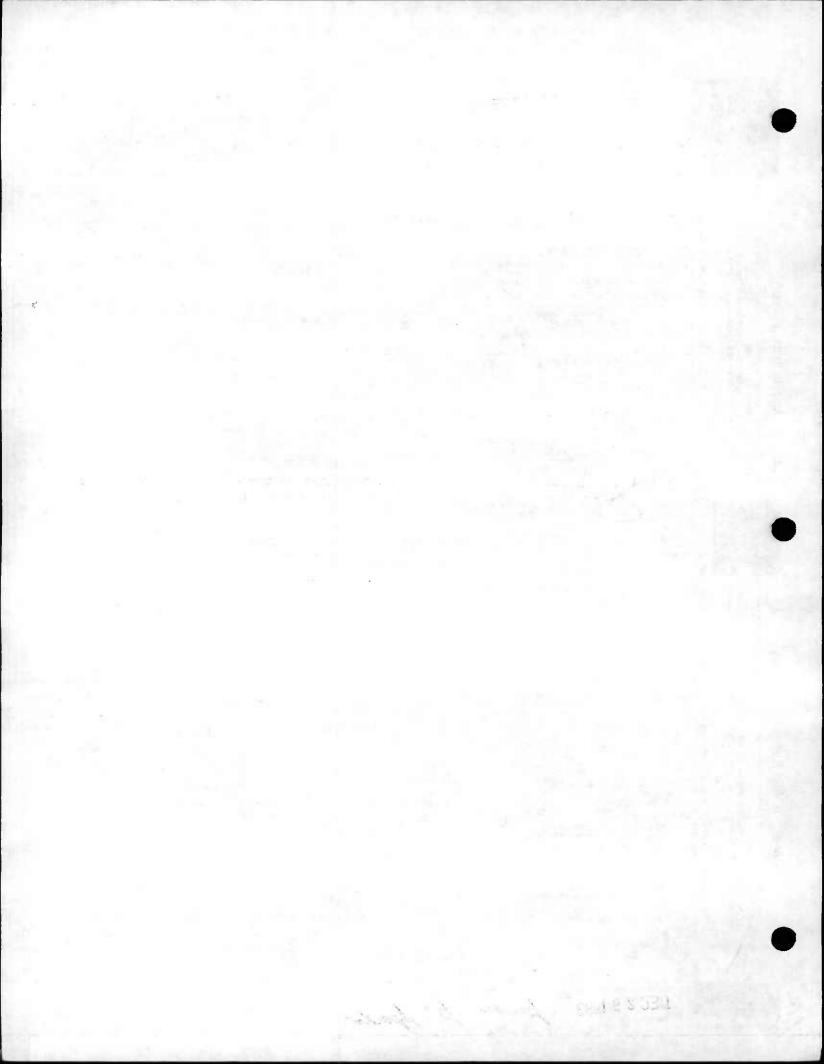
RONALD KEER THOMMS

68760,	
Box	
P.O.	
of Vital Records, P.O. Box 68760,	
Vital	
to	
Division	

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	1. Decedent's Name (First, Middle,	Last)				2. Dete of Dec	ath		3. Time of Death
Physician	Thomas Rona	ld Kerr				Month 12	2 5	Year 99	8:00P.M
/Medical Examiner	4a Fecility Neme (If not institution, g	give street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
	EastPoint Nursing	and Rehab	Center		Dunda1k		Ba1	timore	
Funeral	5. Social Security Number 6	Sex 7. Ag 1 → M 2 □ F	e (In yrs. last birthda	(y) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De	h y, Year)	9. Birthplec	e (Stete or Foreign
Director	Usuel Residence of Decedent	X	60 Yrs.			02-12-	- 1939	Mary!	land
Page 1	10a. State 10b. County		10c. City, Town or	Location				10d.	. Inside City Limits
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eth with the Marylar 23a or 28a-f ahow wat be notified at rai Director	10e. Street and Number		Baltim	10f. Zip Code			10g. Citizen of	Whet Country	?
23a o BI D	5110 Frankford Av	Je.		2120	16		U.S.	Δ	
r tema 23 siner must Funeral	11. Marital Stetus	12. Wes Decedent Armed Forces?	Ever in U,S. 13	3. Was Decedent of H		pecify Yes or No-		a - American	
o d			No	1 Yes 2 No		riican, etc.)	Specify		
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To To	David Keri				Marie	Ridgewa	ч		
Taun Taun	19a. Informent's Neme/Reletionship	(Type, Print)	19b. Ma	ailing Address (Street	and Number or Rur	ral Route Numbe	er, City or Town,	Stete, Zip Co	ode)
m 27 her 1	Carnell Welsh (St	tep-daughte	r) 511	O Frankfor	rd Ave. Ba				21
± 5	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3	☐Removel from Stete	cemetery, c	remetory or other ple	ce)	Dete	20c. Location -	- City or Town	, State
T S	4 Donetion 5 Other (Spec		BaltW	ash. Crema		12-28	Laurel,	Mary1	land
D A P	21. Signature of Funeral Service Lic		1 -	22. Name end Addre Moran-Asht	on Dahwar	relet Fur	oral Uc	omo Tr	
	1 Vat			3000 E. Ba	altimore 9	St Ralt	imore	MD 212	224
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N. N.		d							
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detached for use es detached for use es Physician/Mex	Pert it. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	ven in Pert f.				e cause of death?
by Pt						10	Yes 2 No	3 Probab	oly 4 Unknown
d by						24a. Wes	an autopsy	24b. Were	eutopsy findings
pege 2 should							rmed?	comp	ble prior to letion of cause
Pege 2								of dea	
S. P.	25 Was once referred to a dis-					101		1 U Y	es 200 No
director, peg	25. Wes case referred to medical examiner?	Hospitel:		Oth	26. Plece of Deat				
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fical	29a. Certifier 1 Certifying F	Physician: To the best of aminer: On the basis of	examination end/or	eth occurred et the tir investigation, in my o	me, date end place, ppinion, deeth occur	end due to the red et the time,	cause(s) end ma dete end place,	anner es state and due to the	ed. e ceuse(s)
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1	2 Man			D	30041		d!	CCON	VI.
1	30. Name end eddress of person who	Sa band	11	e, Print)	30641 Te 308	FU 1	1.E0 to	auci	
GA	31. Dete filed (Month, Day, Year)		er's Signature	000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Beds	line	7
State Registrar	DEC 2 9 1999	6. Program	. J orginature	,				MO	12/20/
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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Anna Helen Kessler 9:30 A.M. December 26 1999 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 310 Second Avenue Baltimore Baltimore If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) June 24, 1922 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 🖾 F Yrs 213 18 1436 Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZX No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Second Avenue 21227 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Anna Goka Joseph M. Przywara 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2024 Harman Avenue Baltimore, Maryland 21230 John Kessler Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 12/29/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Holy Rosary Cemetery 21. Signetura of Funeral Service Lig 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 emurousa one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 234. Part1. Enter the diseas shock, or heart failure. congestive Hant Failure Immedieta Ceuse (Finel diseese or condition rasulting in daath) RS Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy performed?

Physician /Medical Examiner

attending physician and for use as the buriel-tren

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certificate

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After

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within 24 hours eff To the Funeral DI completely filled in

To the Within 2

Hospital or Attending Physician:

signed b

The law requires that the death certificete be exacuted

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Physician

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Director

Funeral

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I be filed within 72 hours efter death with the Marylen ntel Hygiene.
ed other than "natural", or ftems 23s or 28s-f show event, the Medical Enterprise research the modern and the modern

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is merked other any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Disease or injury that initiated evants resulting in death) Lest 25. Was case referred to medical examiner?

1 Yes 2 No

28d. Describe how injury occurred

heck	only	one)	

1 ☐ Yes 2 ☐ No

2	6. Place of Death (C	heck only one)	
Other:	4□ Nursirig Home	5 Pesidenca	6 □Other (Specify)

27. Manner of Deeth
1 Naturel
2 Accidant
3 Suicide

4 ☐ Homicide

1 Yes 2 No

5 Pending investigation 6 Could not be detarmined

28a. Data of Injury (Month, Day Year) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify)

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

28c. tnjury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) end mennar stated.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

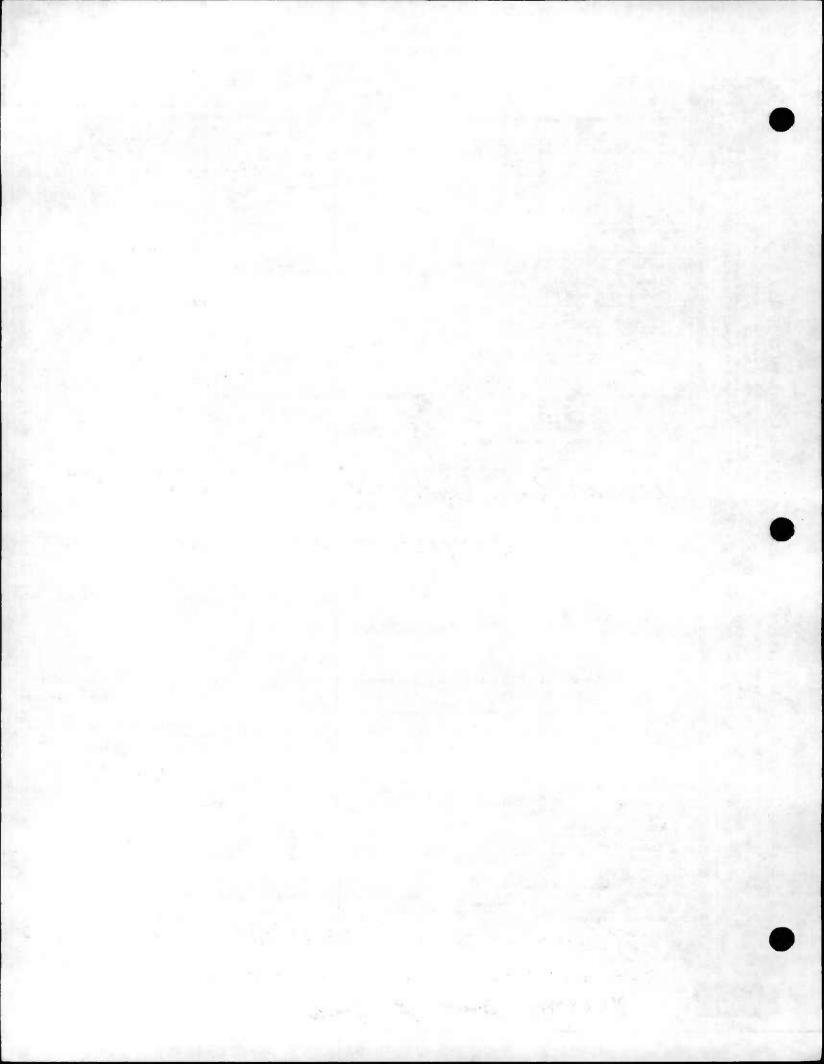
Dr. Kenneth Williams 31. Dete filed (Month, Dey, Year)

1120 N. Rolling Road Baltimore, Maryland 21228

32. Registrar's Signature

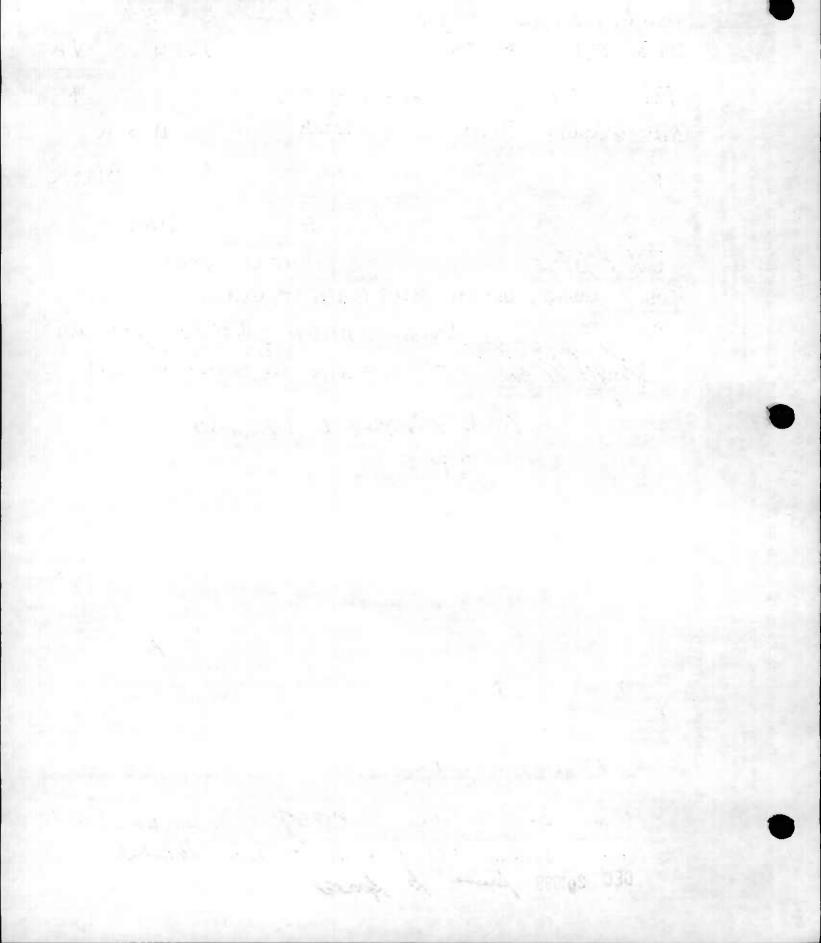
Registrar **DHMH 16 Bev 6/95**

State



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GEOrgetta 102 DECEMBER /Medical 4b, City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner General BAItimore 7. Age (In yrs. last birthday) Maryland 5. Social Security Number 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sax **Funeral** 219.30.499 Months Days Hours 1 M 25 F Director Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryler Department of Health and Mentel Hygiene.
Important: If them 27 Is merked other than "natural;, or items 23a or 23a-f show any Injury or other traumatic event, if a Maries Examines man be notified as any Injury or other traumatic event, if a Maries Examines man be notified as 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 3920 S NTIVE 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Status Black White etc. Mo0547329 1 Never Married 2 Married 1 ☐ Yes 2 No 1□ Yes 200 No Specify: Black by 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewite OME 6 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 678EN Harriet 0 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chapman 20b. Place of Disposition (Name of cametery, cremetory or other placa) St Daughter Baltimore 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville 12-30-99 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 6 dry P. March FUNERAL HOME 21. Signature of Ferreral Service Licensee 270 FredHilton Pass Baltimore, MD 21229 be 1.0 computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as/a consequenca of): Examiner 2615 ettending physician end for use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 □ Probably 4 Unknown 1 Yes 2 No by 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed pital or Attending Physician: The law ours efter death.

eral Director: After this certificete has I filled in by the funeral director, page 2 it 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 New Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homleide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Donne 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ann 2**9**1999 32/Registrer's Signeture State Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death **Physician** December 27 1999 Ronald George /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice @ Mercy Baltimore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 23, 1945 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1. M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Yrs. Director 54 214-44-3249 Usuel Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show with injury or other traumatic event, its Medical Examinal must be notified at price. W Yes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 231 S. Bouldin Street U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yès, Give Yaar or Detes: 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Warehouse Manager Pipe Supply Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) Be Frank Lang MargaRET Christine Nelles 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Michael Lang (Son) 1930 Prentiss Drive, Downers Grove, Illinois 60516 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Sacred Heart of Jesus 12/30/99 Baltimore, Maryland 22. Name and Address of Facility Schimuner Funeral Home Inc. 21. Signature of Funerei Service Licensee Mare T. Zavoyna 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the diseasa of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only ona cause on each line. **Physician** Carcinon Immediate Ceuse (Final disease or condition resulting in daath) /Medical Lell Examiner Due to (or es e consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician end the burial-trans Sequentielly list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Lest Due to (or es e consequence of): P.O. Box 68760. Dua to (or es e consequence of) Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ ate has been signe pege 2 should be Be Completed 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Yes 3 No Other: 4 Nursing Home 5 Residence 6 Other (Special) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) 27. Menger of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation Naturel To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af 1 Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicida Certifier (Check only one)

Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, date end place, and dua to the cause(s) and mannar as stated.

Certifying Physician: To the best of my knowledge, daeth occurred at the tima, date end place, and dua to the cause(s) and mannar as stated.

Certifying Physician: To the best of my knowledge, daeth occurred at the tima, date end place, and dua to the cause(s) and mannar as stated. 29a. Certifier completely 29d. Date signed (Month, Pay, Year) 29b. Signetura and vitla of certifia 29c. License number 40854 30. Nama and afforess of person who con ted cause of deeth (Item 23a) (Type, Print) Baltung cuseber 31. Date filed (Month, Day, Year) DEC 29 32. Requirer's Signature State

DHMH 16 Rev 6/95

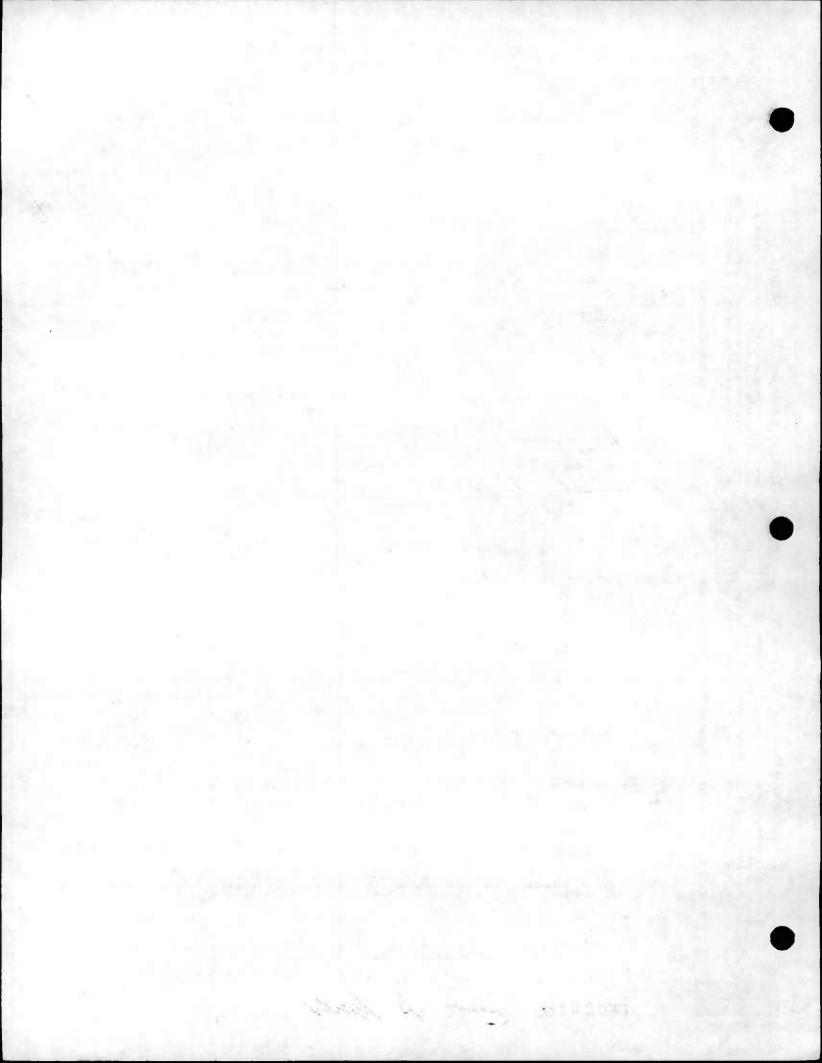
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** DEC 7:55 PM 1-OILEY ENARD /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia **Howard County General Hospital** M Under 1 Yeer | M Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Howard 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sax. 1 M 2 F **Funeral** Months 89 Yrs. Director 212-05-5895 February 4, 1910 Maryland Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits show permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryls Department of Health and Mentel Phytiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examinat man be notified as 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 2901 Chestnut Hill Drive U.S.A. Completed by Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1□ Yes 2 No 21215-0020 1942 Specify: Specify: 3 Widowed 4 □ Divorced White 1945 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) **BGE** 8 Supervisor Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be John Lokey Sarah Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3636 Dry Creek Court Ellicott City, Maryland 21043 Mr. Thomas Lokey 20b. Plece of Disposition (Nama of cematery, cremetory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Services, Inc. 12/27/1999 Sykesville, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M01204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disaasa or condition resulting in death) /Medical (Weominia Examiner Dua to (or es a consequence of): Physician/Medical Examiner Conce strue Heron solut for use as the burial-transit or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immediate cause. Entar Undarlying Cause (Disease or injury that initiated avants resulting in daath) Last Due to (or es a conseque P.O. Box 68760. Monkes Dua to (or as e consequence of): Cenelius Vasulm sate has been signed by the e pege 2 should be detached it Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, P 24b. Ware autopsy findings available prior to Be Completed 24a. Was en eutopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Division of Vital completely filled in by the funeral director, 25. Was casa raterred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Medical Certification: To 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Affer 1 Naturel 5 Pending Invastigation 1 Yas 2 No 2 Accident To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 6 Could not be datamined 3 Suicida 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mennar stated. 29a. Cartifiar (Check only 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cellos 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) BURN, STRU Columbia, MO AL 11055 61170 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2 9 1999 DHMH 16 Rev 6/95

ORIGINAL



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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month KOSEANNA LERIE ANASTASIA DECEMBER 24TH 1999 11.00 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE HAR BOR CENTER 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 M 2 F Yrs. 064 20 3694 Oct. 31, 1925 New York Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No Anne Arundel Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 306 Hillcrest Avenue 21225 U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas: 11 Marital Status 14. Race - American Indian. Black, Whita, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) College (1-4or 5+) 11th Secretary Harbor Hospital 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Catherine Sheridan Vincenzo Maiorana 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Lerie / Son 4011 Highland Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Removat from State Glen Haven Memorial Park 12/29/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Gonce Funeral Home P.A. 236. Part1. Entar tha disaasa, or combligations that caused the death. Do hot enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart fellure. List phily on a cause on each line. 4001 Ritchie Highway Baltimore, Md. 21225 Approximata Interval Between Onset and Death Immedieta Causa (Finat diseesa or condition resulting in death) HEART YEARS CONGESTIVE FAILURE Dua to (or as a consequence of): DILATED 10 YEARS CARDIOMYOPATHY Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or Injury Dua to (or as a consequence of) that initiated events rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FAILURE RENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy MFLLITUS 1 Yes 2 No 1 Tyes 2 No 25. Was casa raferred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items

permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if from 27 is marked other than "ru eny injury or other traumatic evant. In acce.

death

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Director

Funeral

Be

Physician/Medical Examiner Completed Be Medical Certification: To

27. Mannar ol Death

Natural 2 Accidant

3 Suicida

29a. Certifiar

4 THomicide

29b. Signatura and titla ol cartifiar

5 Panding invastigation

6 Could not be datarmined

attending physician and for use as the burial-transit The law requires that the death certificate be executed certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

State Registrar 32. Registrar's Signature

28a. Data of tnjury (Month, Day Year)

29c. License number 1280

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

29d. Data signed (Month, Day, Year) DECEMBER

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

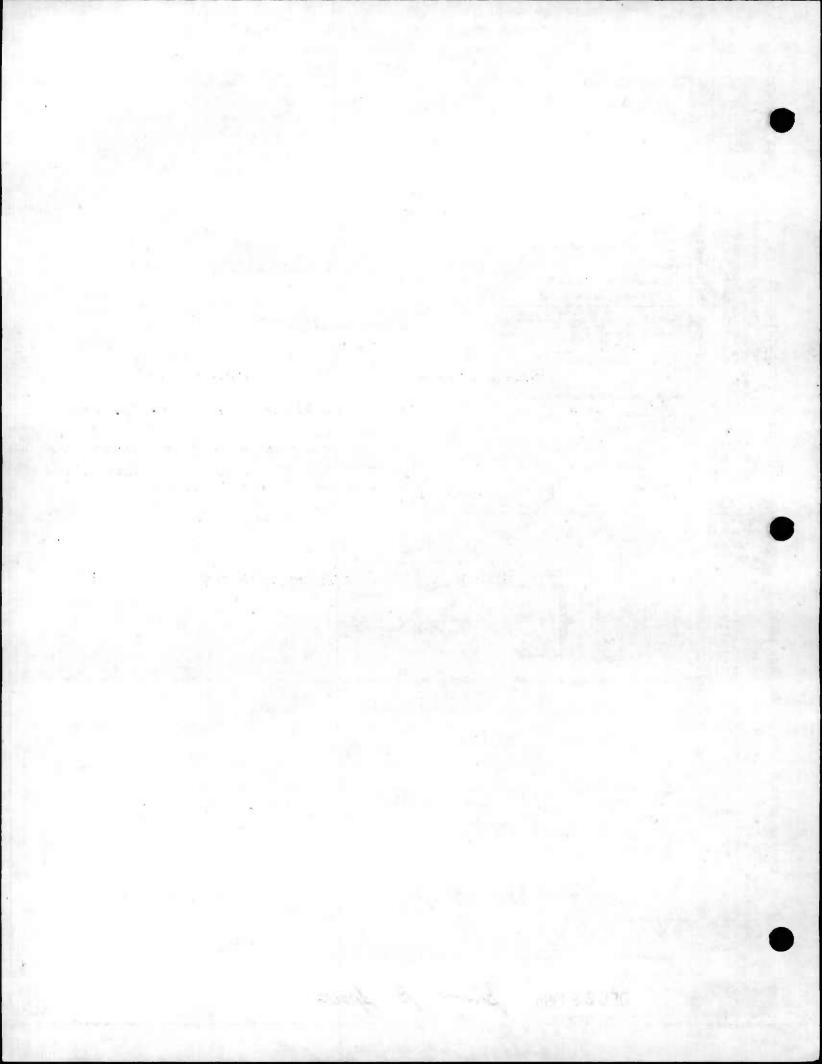
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

aplos

HOSPITAL CENTER, 3001 S. HANOVER, STREET, BALTIMBRE RASTOGI 31. Data liled (Month, Day, Year) DEC 2 9

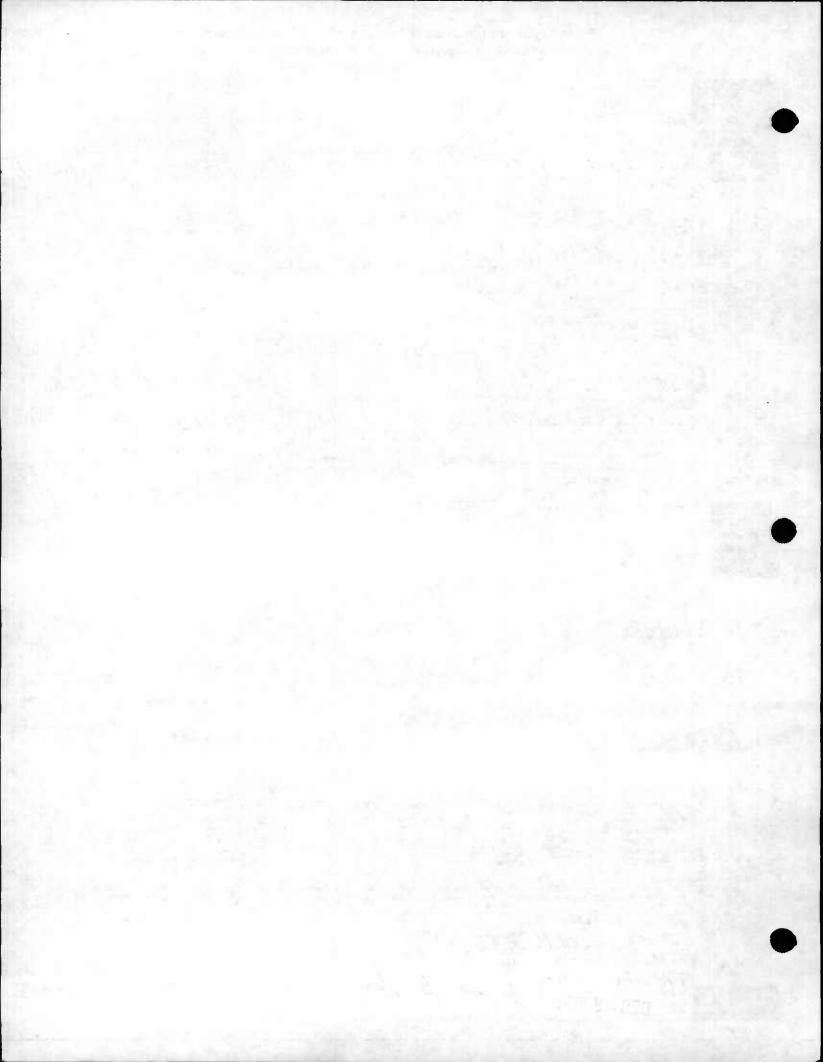
28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)



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	State	31. Date filed (Month, DEC 2	ay, Year)	43 Begistr	ar's Signator	pph		TATI LIND	re. Marc	ATORIO STS	OT
7 /	Registra	DEC 2	9 1999	1							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2 Date of Death Day **Physician** 10:20 Am ARTHUR LANKFORD, JR. 1999 Jecember 20 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne ARUNDEL bhen HRundel HOSPITAL DURNIE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours XXM 2DF 84 214-14-3652 Yrs. 06-24-1915 MARYLAND Director Usual Rasidence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d, Inside City Limits MD. ANNE ARUNDEL **PASADENA** 1 ☐ Yas XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5166 MOUNTAIN ROAD 21122 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? XX Yas 2 No 1942. If Yas, Giva 1945. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Never Married XX Married 1 ☐ Yes Mo Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) PLUS Elementary/Secondary (0-12) PHYSICIAN SELF EMPLOYED 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Pages 1 and 2 should be fishment of Health and Mental H sant: If them 27 is marked off Be **ARTHUR** LANKFORD, EUNICE E. HOISER 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ELLA LOUISE LANKFORD (WIFE) 5166 MOUNTAIN RD., PASADENA, MARYLAND, 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation XX Removel from Stata **EVERGREEN CEMETERY** 12 - 30OWEGO, NEW YORK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 21 Signature of Funeral Service Licenses 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical CONGBIWE Examiner Dua to (or as e consequence of): Examiner INFARCTION myocaral Ar Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disaase or Injury Dua to (or as a consequence of) burial-tran ASTORN Physician/Medicai that initiated events rasulting in death) Last Dua to (or as a consequence of) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PV been signe should be 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 20 No 1 ☐ Yas 2 ☐ No certificate 1 Yes 25. Was casa referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 2 Inpatient Certification: To 1 ☐ Yeş 2 No 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Affer 5 Pending 1 Natural 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident invastigation 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be datarminad 3 Sulcida 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida

Division

lew requires that the deeth certificate be executed

P.O. Box 68760,

Records,

of Vital

or Attending Physician:

Hospitai

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within 2 \$

Maryland

State Registrar

Medicai completaly

29a. Cartifiar

(Check only one)

29b. Signatura and titla of cartifiar

mo

301 HBRATA

30. Nama and atterass of person who completed causa of death (Item 23a) (Type, Print)

myy

DHMH 16 Rev 6/95

Arme,

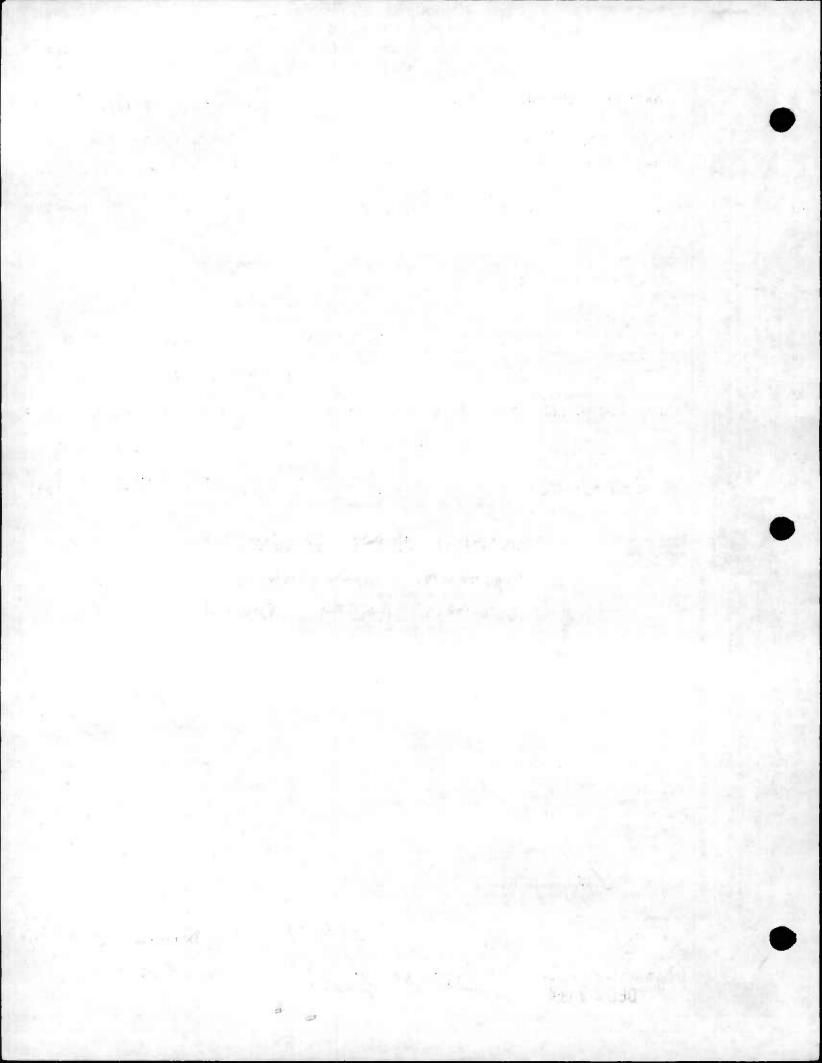
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Certifying Physician: To the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

alin

29c. License number

29d. Date signed (Month, Day, Year)

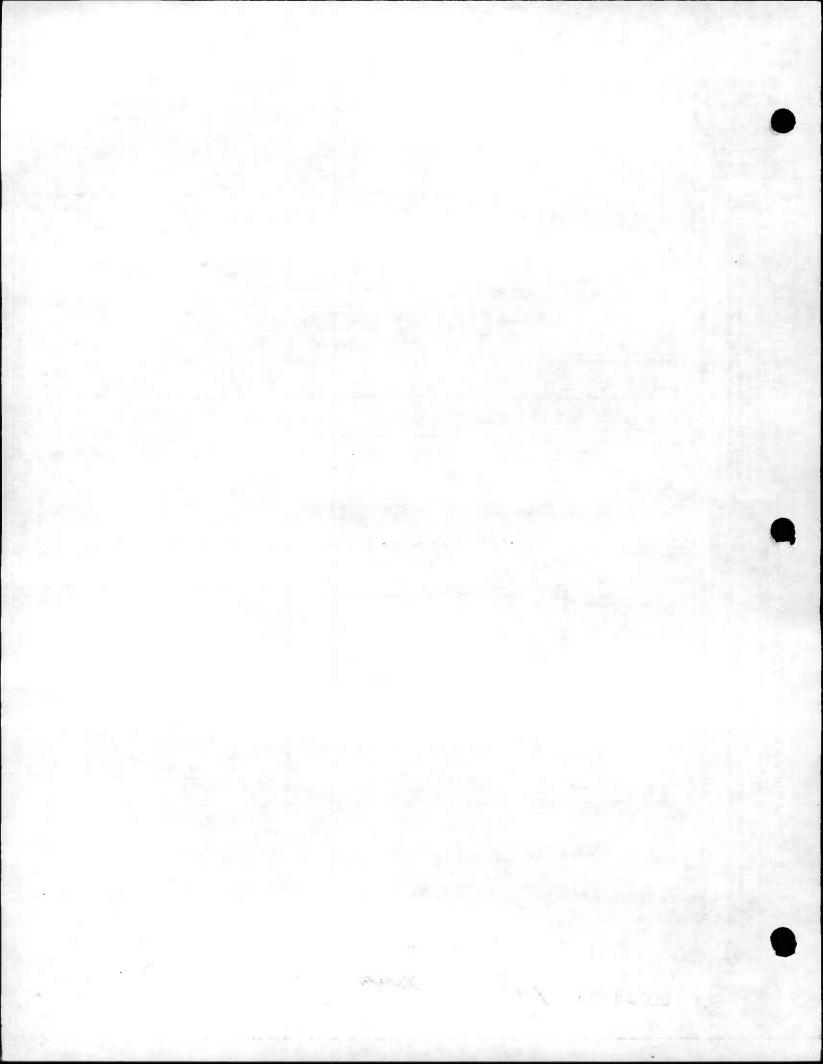


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1030 Day Month **Physician** ISHAM MOORE 12 99 24 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LongGreen Center Genesis Elder Care Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□ F Months Days 217-14-3545 80 Director 06-20-19 NC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examination of the Incurted any injury or other traumatic event, the Medical Examination. 1 Yes 2 No Director MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1208 Autumn Leaf Court 21202 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: XXNever Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) High Sch. Grad Laborer various trades 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isham Moore Beatrice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda 2 1 2 0 6 4330 Parkside Drive Baltimore, Maryland Sellers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 12-30-99 Owings Mills, 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. o not entar the mode of dylng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Condro myo path disease or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner malm requires that the death certificate be executed physician and stransitions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): multiple denibitions Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): attending pl marctur signed by the at d be datached for Part II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Joint þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No Attending Physicien: funeral director, Be 25. Was casa rafarrad to medical examiner? 26. Placa of Daath (Chack only ona) Other: 4 Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Pending 1 Natural death. 1 Yes 2 No investigation 2 Accident or Attendation of Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide Funeral Dire Hospital 🔁 Certifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as statad. 29a. Cartifian edicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated. (Check only one) To the To The To the Connoles 29c. Licanse number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MID D 31464 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) of finte 30 f. Bull. MD Enlaw MI 821 N 32. Regisfrar's Signature HASHMI SHOAILS A. N. 31. Dafe filed (Month, Day, Year) State DEC 29 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certif	ficate of	Death		Reg. No.	9 40	155	
	ecedent's Name (First, Middle, Las	0		H 16		2. Date of D Month		3. Year	Time ot Death	
sician edical	MILDRED			MA	VE	DEC.	24.1	999 UN	KNOWN	
miner 4a F	acility Name (If not institution, give	street and number)		1	4b. City, Town, o	r Location of Dea	th 4c. Count	ot Death		
	SOI DOLP	HINSTR		1303	BAL	TIMORE	=	NIA		
ral 5. So	cial Security Number 6. Se	7. Age (h	N	Under 1 Year lonths Days			rth ay, Year)	9. Birthplace Country)	State or Fore	
or 24	10-12-0111	J 441	Yrs.			FEB. 1	9,1922	NORTH	+ CAROL	
	I Residence of Decedent State 10b. County	10	c. City, Town or Locati	on				10d Ir	side City Limi	
5 1/1	MILLIAN A	IA		0	0	10- 1	71		X Yes 2□	
0 /9/	Street and Number	177		10f. Zip Code	9LT/M	ORE C	10g/Citizen of	What Country?		
Funeral Director	01 104	A STREE	- 4		2121	17	7			
9 11, N	faritat Status	12. Was Decedent Eve	7 APT 1303 rin U.S. 13. Was	Decedent of	Hispanic Orlgin? (pan, Mexican, Pue	Specify Yes or N		SA - American In-	dian,	
	□ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give		,		rto Rican, etc.)		ck, White, etc.		
	Widowed 4 □ Divorced	It Yes, Give Year or Dates:	10	Yes 2, No	Specify:		Specif	BIA	NO	
Completed 10	15. Decedent's Edu (Specify only highest grad	ucation	16a. Decedent	's Usual Occu	pation	ndkina	16b. Kind of B	usiness/Industry		
Ele	ementary/Secondary (0-12)	College (1-4or 5+)	^		during most of w					
5/6	THGRADE		Do.	MEST	7c W				MILIE	
a 17. Fi	ather's Name (First, Middle, Last)		, ,		18. Mother's No	ame <i>(First, Middl</i> e	e, Maiden Sumer			
2 4	DILLIE		UILLIA.	MS	ANN	IE		Mo	ORE	
19a.	tntormant's Name/Relationship (7)	ype, Print)	19b. Mailing A	ddress (Stree	t end Number or f	Rural Route Numi	ber, City or Town	, Stete, Zip Code)	
	CHARD WILL		EW) 6360		RAWAY		AL TIMOR			
	Method of Disposition □ Burial 2 Cremation 3 □ F		20b. Place of Disposition cometery, cremate	on (Neme of ony or other pla	ice)	Date	20c. Location	- City or Town, S	itate	
	Donetion 5 Other (Specify))	METRO CR	EMAT	ORY	12-29-99	BALT	IMORE.	MARY	
21.5	Signaturn of Funoral Service Licens	900	22. N	ame and Addr	ess of Facility	Roselle	TO FI	NERA	1 Ho	
9	Latell	1. W 104	a 39	SEL	11 FILL T	DNAVE	BALT	MADE M	1-517	
23a.	Part1. Enter the disease, or compleshock, or heart taiture. List only o	lications that caused the	death. Do not enter the	ne mode of dy	ing, such as cardi	ac or respiratory	arrest,	: App	oximate	
an	SHOOK, OF HEAR (MINUTE. LIST ONLY O							Ons	val Between et and Death	
al tmme	ediate Cause (Finat	Athory	sclenk	'c CA	dioVA	scula	1 Don	5	40015	
er result	the mediate Cause (Final disease or condition resulting in death) Atthero 5 clerch'c Cardiava vullar Descript 5 year put to (or as a consequence of):									
Sequent of the sequen										
Sequif any	pentially tist conditions,	Due	to (or as a consequen	ice of):						
	ventially tist conditions, y, leading to immediate e. Enter Underlying se (Disease or injury									
esult	nitiated events ting in death) Last	Due	to (or as a consequen	ce ot):						
5		d								
Physician										
Part II	I. Other significant conditions cor	ntributing to death but no	ot resulting in the under	rlying cause g	ven in Part I.	23b. Did	tobacco use co	entribute to the	cause of dea	
£						1□	Yes 2 No	3 Probably	4 Dunki	
- b										
Completed						24a. Wa: perl	s an autopsy ormed?	24b. Were at available	topsy tinding prior to ion of cause	
ldu		-						ot death		
S						10	Yes 2 ANO	1 □ Yes	2□ No	
25. W	/as case referred to medicat xaminer?	.=				eath (Check only	one)			
-	Tes Ziernio	lospitat:		JU DUA		Home 5 1 Res				
27. M	anner of Death Maturat 5 ☐ Pending	28a. Date of tnjury (Month, Day Ye		28c. tnju		28d. Describe	how Injury occur	red		
75	☐ Accident investigation ☐ Suicide 6 ☐ Could not be				Yes 2 □ No					
E 4	Homicide determined	28e. Placa of Injury - building, etc. (S	At home, tarm, street, specify)	factory, office		28f. Location City or To	(Street and Num. own, State)	ber or Rural Rou	te Number,	
2										
	(Check only 2 Medical Exami	ner: On the basis of exa	mination and/or invest	curred at the t igation, in my	me, date and place opinion, death occ	e, and due to the curred at the time	cause(s) and m date and placa,	anner as stated. and due to the	ause(s)	
	one) Signature and title of certifier	and manner stated.		20a Licen	en number		20d Date signs	d (Month Day		
_ 290. 8	Signature and title of certifier	0/	7 MD	290. LICON	oo number		Zou. Date signe	d (Month, Dey,	1001)	
	coacas	000	2	PI.	58/2		Nece ml	28	1999	
30 N	ame and address of person who co	ompleted cause of death	(ttem 23a) (Type, Prin	t)	0 L	1	1.1 -			
) 1/		1 MN DE	Maise S	trades to	KP1- Nec	-Hum 1	VM C	-1156		
H	TROUD 1506	1-10 C)	1141910	AUG /	1000			1120		
State 31. Do	ate filed (World: Jet Jet.)	A PASE: Hogistrar's	(Item 23a) (Type, Prin	JUG !						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 3 3:20pm IC KRIPE **Physician** BERNICE 2 /Medical 4b, City, Town, or Location of Deeth Fecility Neme (If not Institution, give street end number) 4c. County of Deeth **Examiner** HOSP, TAL BACTIMOZE If Under 1 Year If Under 24 Hrs. 9. Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□ M 20 F Deys Months Hours 215-34-1797 Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 □ No Director NA 28a-f altimore 10g. Citizen of Whet Country? 10f. Zip Code 10e Street end Number items 23a or .S.A 41229 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give 8 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black by 3 Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working
life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Harbor College (1-4or 5+) than Elementery/Secondary (0-12) Senior Nursing permit. Pages 1 and 2 should be lited w. Department of Health and Mental Hygien Important; if hem 27 is marked other the any injury or other transment. our grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be GIIMore Graham 110 1ae 19b. Mailing Address (Street end Nymber or Rural Route Number, City or Town, Stete, Zip Code) 2/2/3 19e. Informent's Name/Reletionship (Type, Print) 29/3 Bryde-Son y Ba Uto Md 20c. Location - City or Town, State 20e. Method of Disposition 20b. Place of Disposition (Neme of gemetery, crematory or other place) Dete 1 Burial 2 □ Cremation 3 □ Removal from State Ustown, Ma YEMOMa 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximete Intervel Between Onset end Deeth ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, heart feilure. List only one cause on each line. **Physician** SEPSIS /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): IRRHUSIS physician and the bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t d be detect 1 □ Yes 2 □ No 3 □ Probably Onknown þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes No No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 10 Inpatient 2 ER/Outpetient 3 DOA After this 27. Mepmer of Deeth 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 2 Accident 5 Pending Investigation r death. 1 Yes 2 No or Attend efter death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital C To the Hospital
within 24 hours e
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TA, ON 42634

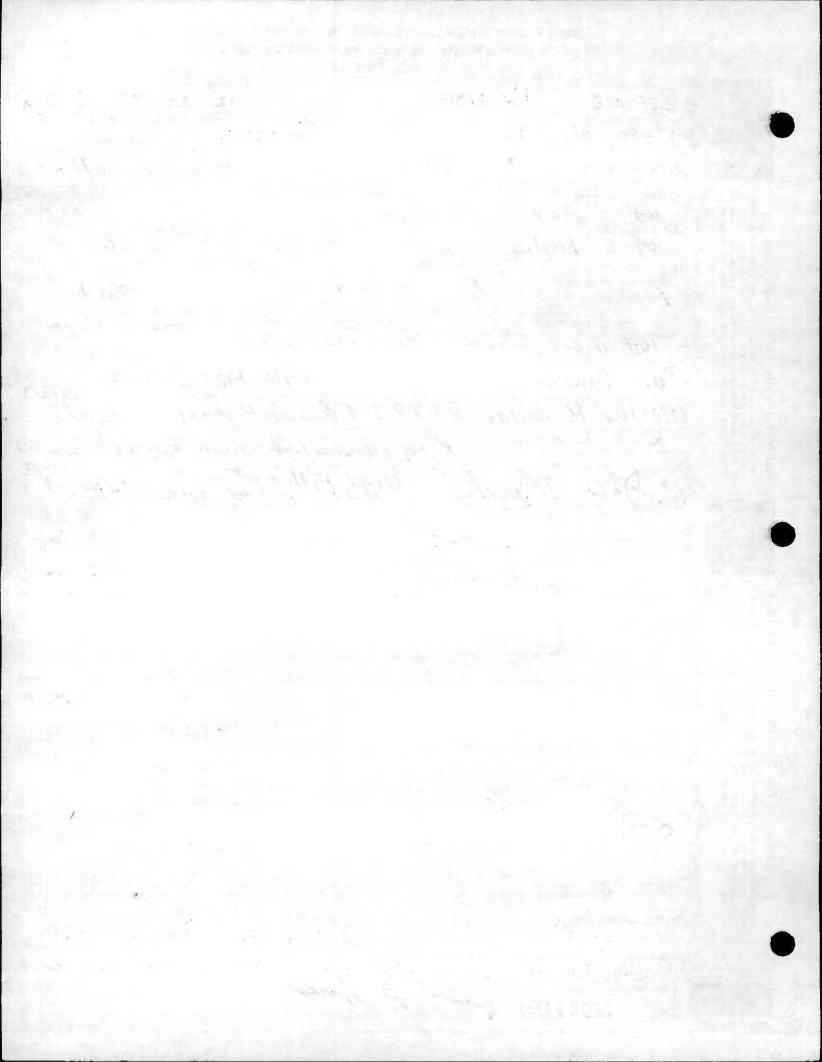
PAUL PLACE

BACTIMORE MO

State Registrar 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

31. Dete filed (Month, Day, Yeer)



Baltimore, Maryland 21215-0020

December 20,1999 @ 1010Am

Charits

Martin, Sr.,

Physician /Medical **Examiner**

the attending physician and hed for use as the buriel-trar To the Hospital or Attanding Physician: The law requires that the death certificate be execu within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-tra P.O. Box 68760,

Division of Vital Records,

21 Usual permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Importent: if item 27 is marked other than "natural", or items 23e or 28a-f show any Injury or other traumatic avent, the Medical Examiner man be routiled at once. 10a. S Director 10e. S 12 Funeral 11. Ma 1 🗆 Be Completed by 3 X Eler 17. Fat CH 19a. ir JOH 20a. M 1X 4 [21. Sig 23a. F Physician/Medical Examiner Seque if any, ceuse. Cause thet ini resultin Part II. Medical Certification: To Be Completed by 25. W 1 27. Ma 2[3[4[29a. C 29b. S 30. Name end address of person who completed cause deeth (Item 23e) (Type, Print)

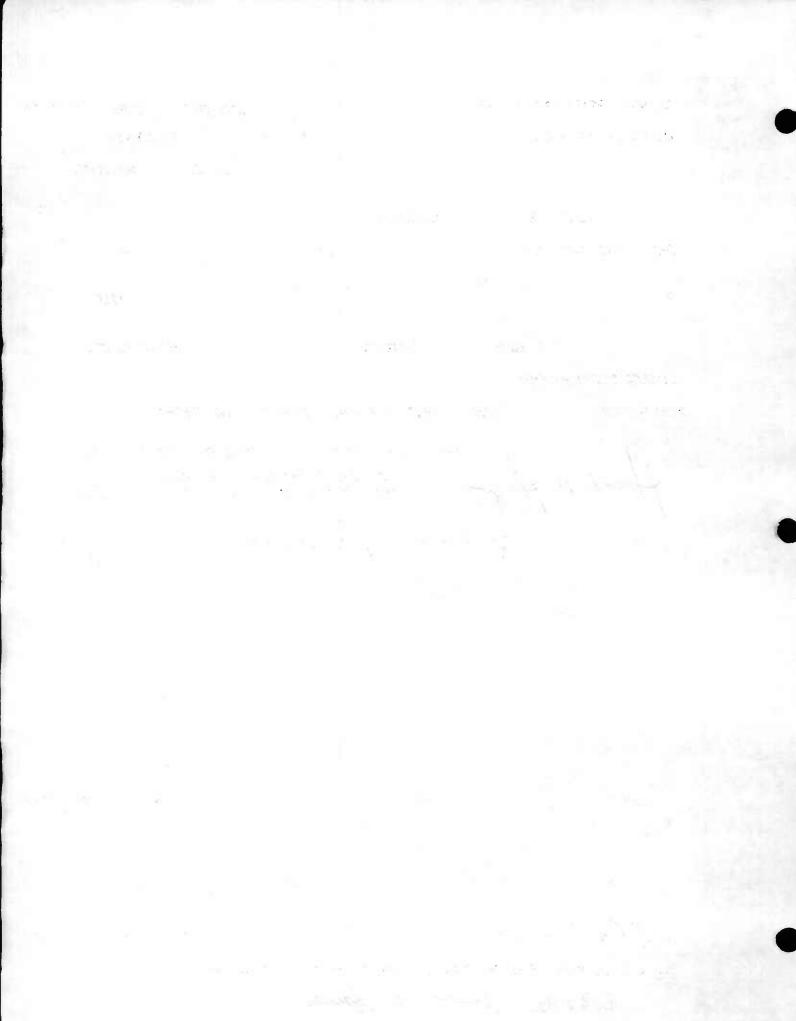
W. Anthony Riley 6701 N. Charles Street Towson, MD 21204 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature State oaks **DEC 29** Registrar

99

State of Maryland / Department of Health and Mental Hygiene 1,0721

		Cei	rtificate o	t Death	1	F	leg. No.	0	70164
1. Decedent's Name (First, Middle, Lest)								Voor	3. Time of Death
CHARLES HENRY MA	RTIN, JR.								10:10 A.
				4b. City, To	own, or l	Locetion of Death	4c. Count	v of Death	
CTLCHRIST HOSPIC	F			TOM	ICONT		חזגם	TMODI	P
		last hirthday)	if Under 1 Ye			R Date of Birth			
	M 2□F	Vec			Min.	(Month, Day	, Year)		place (State or Foreign ntry)
	88	5				4/10/1.	Ļ	MAR:	YLAND
	10c. Ci	tv. Town or Lo	cation					Т	10d. Inside City Limits
									1 ☐ Yes 2 ☐XNo
	RE	GLENDA	LE						10100 200
10e. Street and Number			10f. Zip Code	9			log. Citizen of	What Cou	intry?
1202 SAINT ANDREW	S WAY		2	1239				USA	
11. Marital Status		,S. 13.	Was Decedent of	f Hispenic Or	rigin? (S	pecify Yes or No-	14. Ra	ce - Ameri	
1 Never Married 2 Married	1 ☐ Yes 2 M No		_			o Rican, etc.)	Bla	ick, White,	, etc.
3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1∐Yes 2 x 1N	o Specify.	:		Speci		יסיד
15. Decedent's Educ	cation	16e. Deced	dent's Usual Occ	upation			16b. Kind of E		
(Specify only highest grade	completed)	(Give	kind of work do	ne during mos	st of wor	king			,
Elementary/Secondary (0-12)	College (1-4or 5+)			-7					
	I YEAR	PRI	NTER	10 14-11	ania bi-	nn (Finnt 1 At-d-4)			20
ir. ramers wante (rirst, Middle, Last)				is. Moth				me)	
CHARLES HENRY MAR	TIN				UNA	VATPABLE			
19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Stre	et and Numb	er or Ru	ıral Route Numbe	r, City or Town	, State, Zi	p Code)
JOHN MARTIN	SON	P.O.	BOX 424	4 TIM	JINO	JM, MD	21094		
20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	E 1. 1		Date	20c. Location	- City or T	own, Stete
	emoval from State	cemetery, crer	natory or other p	race)					
	-	RKWOOD	CEMETER	Y		12/28/99	BALTIN	ORE,	MD
21. Signature of Funeral Service License	° / /				-	AT. HOME.	DΛ		
Heathe N.	Harr							. O.	1000
23a. Put1. Enter the disease, or compli	ations the aused the deet	h. Do not ent	er the mode of o	H KAVE ving. such as	ardiac	or respiratory en		ID 2.	1286 Approximate
shock, or heart failure. List only of	a cause of each line.			,					Intervel Between Onset and Death
Immediate Cours (Final	- (*				1	Orioot and Doam
disease or condition	Duly	umi	my 5	1 pro	12 (5			years
resulting in death)	Due to (c	or as e consec	1						0
Sequentially list conditions.	Due to (c	or as a conseq	uence of):						
if any, leading to immediate									
Cause (Disease or injury									
resulting in death) Last	Due to (c	r as a conseq	uence of):						
	•								
Part II. Other significent conditions con-	tributing to death but not res	ulting in the u	nderlying ceuse	given In Pert	i.	23b. Did to	becco uae co	ontribute t	o the cause of death?
						1 🗆 Y	ea 2 No	3□ Pro	bably 4 Unknown
					-				
									ere autopsy findings
						perfor	med?	CC	velleble prior to empletion of cause
								of	death?
						1□ Y	es 2 No	1	☐ Yes 2☐ No
25. Was cese referred to medical				26. Piace	e of Dea	th (Check only or	ne)		1-1
1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	nt 3 DOA	Other: 4 Ni	ursing H	lome 5 Resid	ence 6 Mon	her (Speci	W Hospica
27. Manner of Death	28e. Dete of Injury	28b. Time of							1100/100
1 Naturei 5 ☐ Pending	(Month, Day Year)	Injury			l No				
E LI Mooldonk	One Disease (1)					004 004/1-1 (0	tonat and the	haaa : 0	n / Dougla Alice d
Usual Recidence of Decedent Usual Recidence Usual Reci						ar Houte Number,			
29a. Certifier 1 Certifying Phys	icien: To the best of my kno	wledge, death	occurred at the	time, date ar	nd plece	, end due to the c	ause(s) end m	enner es s	steted.
one) 2 Medicai Examin	er: On the basis of examina and manner stated.	tion and/or inv	restigation, in m	opinion, dea	ath occu	rred et the time, d	ate and place,	, and due t	to the ceuse(s)
29b. Signature and title of certifier	1 1		29c. Lice	nse number		2	9d. Date signe	ed (Month,	Day, Year)
Mark	11.1.	m	2	520.		5	2000	6.	20,1999
71 DUSTON	7/000	-1/	00	3 00	.	l	reen	JEV	~ 1111

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, Last)		Certificate of			9 9	40725			
Physician /Medical	4a Facility Nama (If not institution, give stree	erry	Min	fahell 4b. City, Town, or Lo	Month /2	Day Yes 2 / 9	9 1030A			
Examiner	927 N. Rose S	trest	27-6-2	Baltime		4c. County of D	VA			
Funeral Director	5. Social Security Number 6. Sex 212-74-9047	7. Aga (In yrs. las	st birthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Data of Birth (Month, Day,) 12-16-	(ear) 9.1	Birthplace (State or Foreig Country) MD			
anyland ahow start	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limit			
the Maryling 28s-f sho could be rector	MD NA	Bal	timore				1 Q Yas 2 □ N			
4 0 B	10e. Street and Number 927 North Rose S	treet	10f. Zip Code 21208		109	g. Citizen of What	Country?			
urs a	1 ⊠ Never Married 2 ☐ Married 1	Vas Decedent Ever in U,S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2000No		ecify Yes or No- Rican, atc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black			
led within 72 ho byglene. The Medical II, the Medical Completed	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)	n npleted) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	ing 16	6b. Kind of Busine	ss/Industry			
tal Hygiene ad other that avant, the Be Com	7044 0 7 0	rs.	Lithograph		a (First, Middle, Ma		g Company			
d 2 should be fill the and Mental H 7 Is marked out traumatic avart To Be	James 19e. Informent's Name/Relationship (Type, F	Dudley	19b. Mailing Address (Street	Erma	-1. Courte Mountain	Mitche				
aith an 27 le r r frau	Erma Hatten		927 N. Rose				212			
of Heal itam 2 other	20a. Method of Disposition	20b. Pled	e of Disposition (Name of			Oc. Location - City				
permit. Page Department of Important: If i any injury or page.	15∏βurial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	ver from State	netery, crematory or other plant kwood Ceme		28-99	Baltimo	ore, MD			
nedical Examiner use as the burial-transit use as the burial-transit n/Medical Examiner	Immediata Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last d	Entero coc	s a consequence of): LA - PSEU S a consequence of): CAL Back S a consequence of): Fallure	domona	y disea	8€				
sicia	Part It. Other significant conditions contribu	ting to death but not resulting	ng in tha underlying causa gi	ven in Part I.	23b. Dld tob	acco use contrib	ute to the cause of deal			
v requires that the deeth certification is the attending about be detached for use as letted by Physician/Me	Past injection	dry use			1 🗆 Yes	2006 30	Probably 4 Unknown			
The law requires that the deeth cert sate has been signed by the attending page 2 should be detached for use Completed by Physician/M					24a. Wes an performe	eutopsy 24 ed?	b. Were autopsy finding available prior to completion of cause of death?			
Con Con					1 ☐ Yes	200 No	1 Yes 2 No			
certification in the control of the	25. Was casa refarred to medical examiner?	tal:	OH	h	h (Check only one)					
To the Hospital or Attanding Physician: The law within 24 bours after desch. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 members of filled in by the funeral director, page 2 Medical Certification: To Be Compl	1 1 165 2 DO	1 □ Inpatient 2 □ EF	Bb. Tima of linjury 28c. Inju	4 LI Nursing Ho	ma 5 Residen 28d. Describe how		Specify)			
tal or Attanding P rs after deeth. al Diractor: After t led in by the funare Certification:	2 Cuinida 6 Could not be	ia. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,			
ne Hospitu ne Funera petely fille										
To the within the state of the	29b. Signature and little of certifier	pleads	29c. Licens	- 1		1. Data signed (Me				
1	30. Nama and address of person who complete the free of	ted causa of death (Item 2:	3a) (Type, Print) Solving Hopl A. Sparks	cis Bayri	en Hed	Car; Ba	H HD ZIZZ			
State Registrar	31. Data filed (Month, Day, Year) DEC 29 1999	3 Registrada Signetur	D. sparks				- 8			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Physician RHETT 1999 December 11, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Hospital Baltimore Sinai 0+ If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 91 yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1□ M 2X F Sept 29, 1908 VA Director 012-97-2377 **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show e filed within 72 hours after death with the Maryla II Pyglene. other than "netural", or flame 23e or 28a-f ahov vent, its Marian Erwins on 12 a notified 1 Yas 2 No **Funeral Director** MD N/A Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2525 W. Belvedere Ave 21215 USA 14. Race - American Indien, Bleck, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unknown 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No If Yes, Give ∆ Year or Datas: 21215-0020 1 Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if item 27 is marked othe any liuly or other traumatic event Bate. Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD 21215 20b. Placa of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 ▼Other (Specify) in state 21. Signature of Furnish Spring 1900 . Wade, Director 22. Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pirt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, sock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner that the death certificate be axecuted physicien end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): ettending | 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? been si 24a. Was an autopsy Completed hes 1 Yes 2 ANG 1 Yes 2 No certificate Division of Vital 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 PER/Outpatient 3 DOA this Arter deeth.

Vin Director: After the funeral 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Placa of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and titla of certifier

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State

Registrar

31. Date filed (MoDIE

30. Nama and address of person who completed cause of death (Item 28a) (Type, Print) SUNSHING

1999

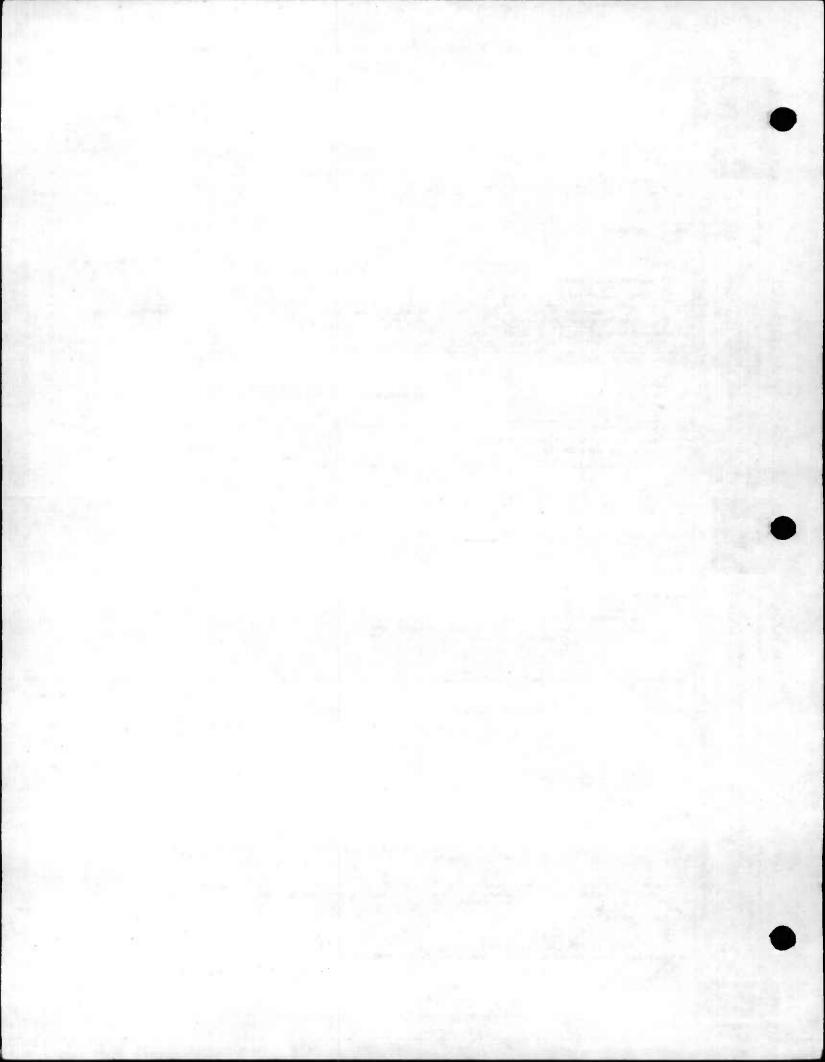
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32. Registrar's Signature

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amend item 23a per me G/80 4/20/W yg

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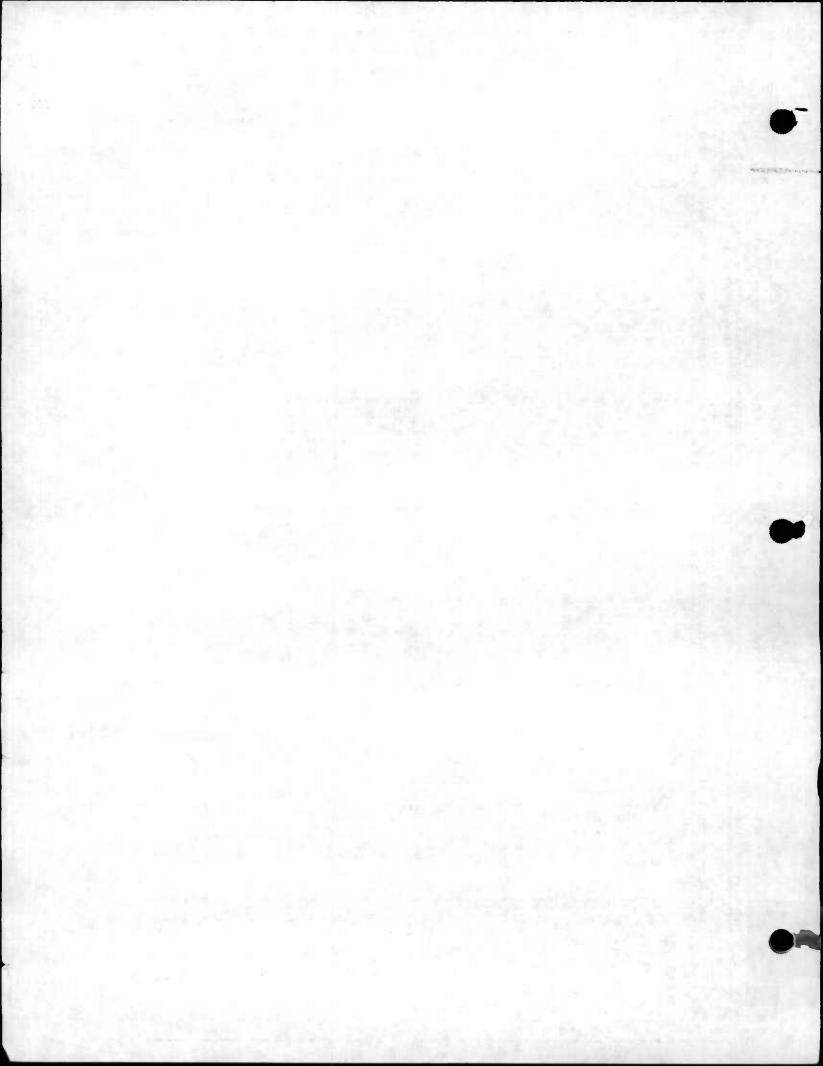


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Examiner		Facility Name (If n UNIVERSI'				DICAL C			BALTI	MORE	cation of Death	4c. Cou	MD	th	- 10
Funeral Director		Social Security Num		Sex 1□M 2只F		(In yrs. last bi		Under 1 Year onths Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birt Co	ountry)	ate or Foreign
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natura desa		15	Decedent's E	ducation	nd)	168	. Decedent's	s Usual Occup of work done	pation during mos	t of work	ina	16b. Kind o	f Business/	Industry	
	E	lementary/Second	ery (0-12)	College	e (1-4or 5+	+)		of work done IOT use retire	ed)						
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	-	4 □ Donation 5	****	-		,,,cbc									
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DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day **Physician** Lowell Emery Miller December 27 1999 9:15 pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 514 Gladhill Road Odenton Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1√2 M 2□ F Months Days Hours 75 Dec. 14,1924 Director 476-16-5965 Minnesota Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas XX No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 514 Gladhill Road 21113 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1♥ Yas 2□ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items 11. Marital Status 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Analyst permit. Pages 1 and 2 should be file.
Department of Health and Mertal Hyp
important: If then 27 is marked other
any injury or other traum-17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Harry C. Miller Emma Olson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Muriel E. Miller (Wife) 514 Gladhill Road, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Metro Crematory 12/29 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Faneral Service Lig 22. Nama and Address of Facility Hardesty Funeral Home, P.A. anch 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** Immediata Causa (Final disaesa or condition resulting in daath) /Medical myelodys plastic syndra Examiner Dua to (or as a consequence of): Physician/Medical Examiner Commary autory of Dua (c) or as a consequence of): attending physician and for use as the burial-transit be axacuted Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Box 68760 CA netasture prostate ** Hospital or Attending Physician: The law requires that the death certificate by Eureral Director: After this certificate has have Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown nsufficience Chronic 24b. Ware autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case retarred to medical axaminer? 26. Place of Death (Check only one) Hospital: Certification: To 1 Yas 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ENatural 5 Pending 1 Yes 2 No invastigation 2 Accidant 6 Could not be datamined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Cartifier 16 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

Registrar

31. Data filed (Month, Day, Year) DEC 2 9 1999

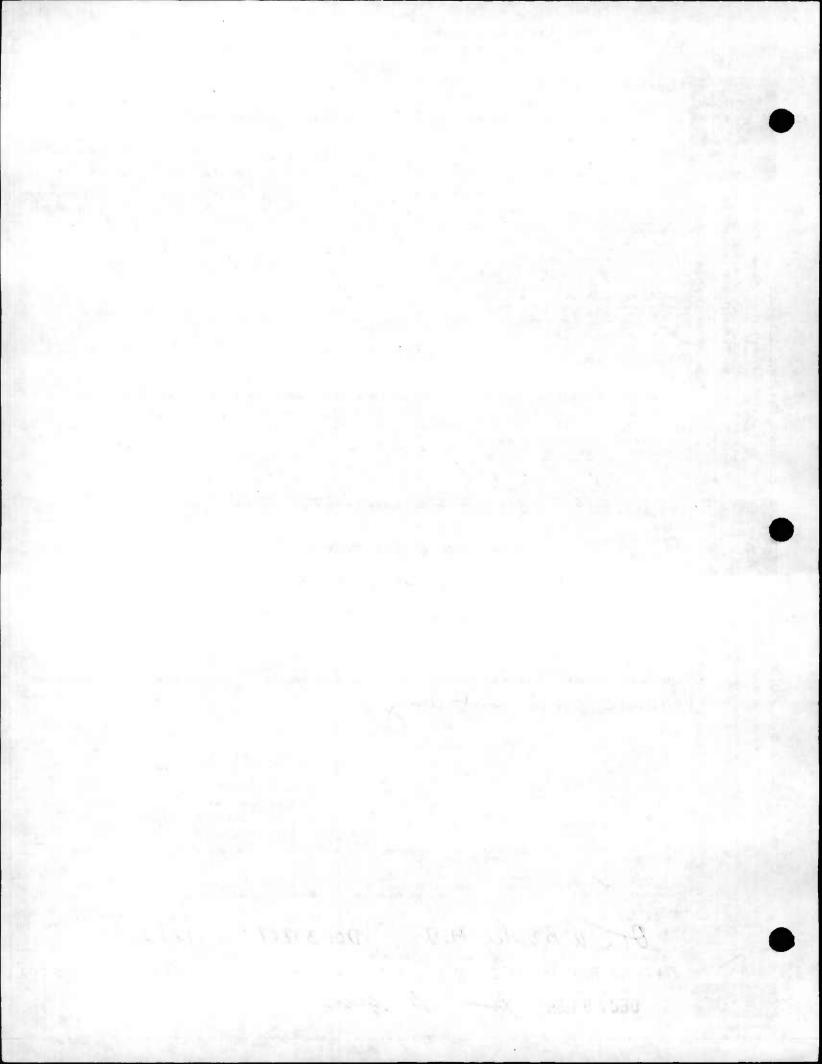
tra WB nwley M.D.

30. Nama and addrass of person who completed capta of death (Item 23a) (Type, Print) Otis W Brawley, M.D., National Cancer Inst, EPS 320, Bethesda, Md 20852 32. Aegistrar's Signatura

DHMH 16 Rev 6/95

29c. License number

D0037811



Please Type or Print in Biack Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

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M a M	cto	St.Croix n/a			Christ		sted					
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d within 72 hours after death with the Manyland giene. If than "neturel", or flerne 23e or 28e-f show the Wedleel Every must be notified at	by Funeral	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:		13. Was Decede If Yes, speci		lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecity Yes or No- Rican, etc.)		ce - America ck, White, c		
n 72 hours "natural",	8	15. Decedent's Ed	lucation	16a. C	Decedent's Usual	Occup	pation	11	6b. Kind of B	Business/Inc	lustry	
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or a the		20a. Method of Disposition 1 Burial 2 Cremetion 3X 4 Donation 5 Other (Specification)		cemetery	Disposition (Nam , cremetory or oth iansted	ther place			Oc. Location Pristia		wm, State d-St.Croix	
nit. Pa artmer ortant:		21. Signeture of Funeral Service Licer			22. Name end	d Addre	ss of Facility					
permit. Departr Importu any int		RT		11	COL	nne'	lly Funer	al Home	of Ess	ex		
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		23a. Pert1. Enter the disease, or com-	plications that caused th	e death Do no	nt enter the mode	e of dyir	ng, such as cardiec	or respiretory erre	st,	21221	Approximate Interval Between	
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/Medical	19	Immediate Cause (Final										
Examiner	127	diseese or condition resulting in death)	a. Multiple	Injur:	ies with	1_Ca	mplication	ns		1		
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and tran	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	conditions, Due to (or as a consequenca of):									
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certificate be executed inding physician and use as the burial-transit	Med	resolung in death) Lest										
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thet the ed by th detach								1 Yss 2 No 3 Probably 4			bably 4 Unknown	
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Her t	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Dete of Injury (Month, Day)	/ear) 28b. Tir		8c. Injui Wor		driver o	f a ni	ckup	ject was a truck that	
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Page i	er	4 Homicide	building, etc.	(Specify)	Street			pr. Gold	en Gro	vě, c	l Route Number, H. Eyans H Hristianst Slands.	
plts ours fille	0	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of r	my knowledge	death occurred a	at the tir	me date and place	SL. CIOI	$X_{\rho} VII$	gin i	stands.	
Fun Fun	edical		niner: On the basis of ex	kamination and/								
To the Hospital or within 24 hours after To the Funeral Dir completely filled in										od (Month	Day Veer!	
T vit		29b. Signeture end title of certifier	290.									
		Stroll	1/100	141	un	0.	C.M.E.	D	ecembe	er 29,	1999	
n		30. Name end address of person who completed cause of deeth (IJem 23a) (Type, Print)										
/		Stephen Radent				nn	Street, E	Baltimore	. Mary	fland	21201	
		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	A	4						
St Realst	ate trar	0000		enera	19	ha	ulas					

Marin Comments

Please Type or Print in Biack indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#6,10b, +10E&19B PER F.H. G779 1-11-2000 J.A. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day MCCLUSKEY FRANCES DECEMBER 27 1999 12:43 PM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth N/A. HARBOR HOSPITAL CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day Yeer) 1930 5. Sociel Security Number Birthplaca (Stete or Foreign Country) 1€M 20 F 199-22-4420 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE MD. BALTIMORE Yes 2 No N/A 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 7128 EASTBROOKE AVE. 21224 USA Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) (Give kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) JAMES A. KANE MARGARITE V. MURRAY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7128 EASTBROOKE AVE., BALTIMORE, MD.21224 CARROLL McCLUSKEY/HUSBAND 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State BALTIMORE WASHINGTON 12/28/99 LAUREL, MD. 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY 21. Signature of Funeral Servica Licansee CHARLES S. ZEILER & SON, INC the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, MD 21224 Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION DAY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEARG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DIABETES MELLI TUS 1 ☐ Yas 2 No 1 Yes 25. Was case referred to medical 26. Placa of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Funeral

Director

the Marylend

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28a-f show any fujury or other traumatic event, the Medical Examines the notified at each

Baltimore, Maryland 21215-0020

physician end s the burial-transit for use as signed by the e ils certificate has b director, page 2 s this

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

Be

2

Certification:

Medicai

funeral After deeth. Director: /

that initiated events resulting in death) Last

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 npatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of

1 ☐ Yas 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

MD

29a. Certifier (Check only one)

1 Yes 2 No

27. Manner of Death

1 Naturei

2 Accident

3 Suicide

4 | Homicide

Certifying Physictan: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

31. Date filed Worth, Paygrand 99

5 Pending investigation

6 Could not be detarmined

Hospital:

RESIDENT

1) 0055481

29d. Date signed (Month, Day, Year) DECEMBER 27 1999

21225

HANOUER STREET

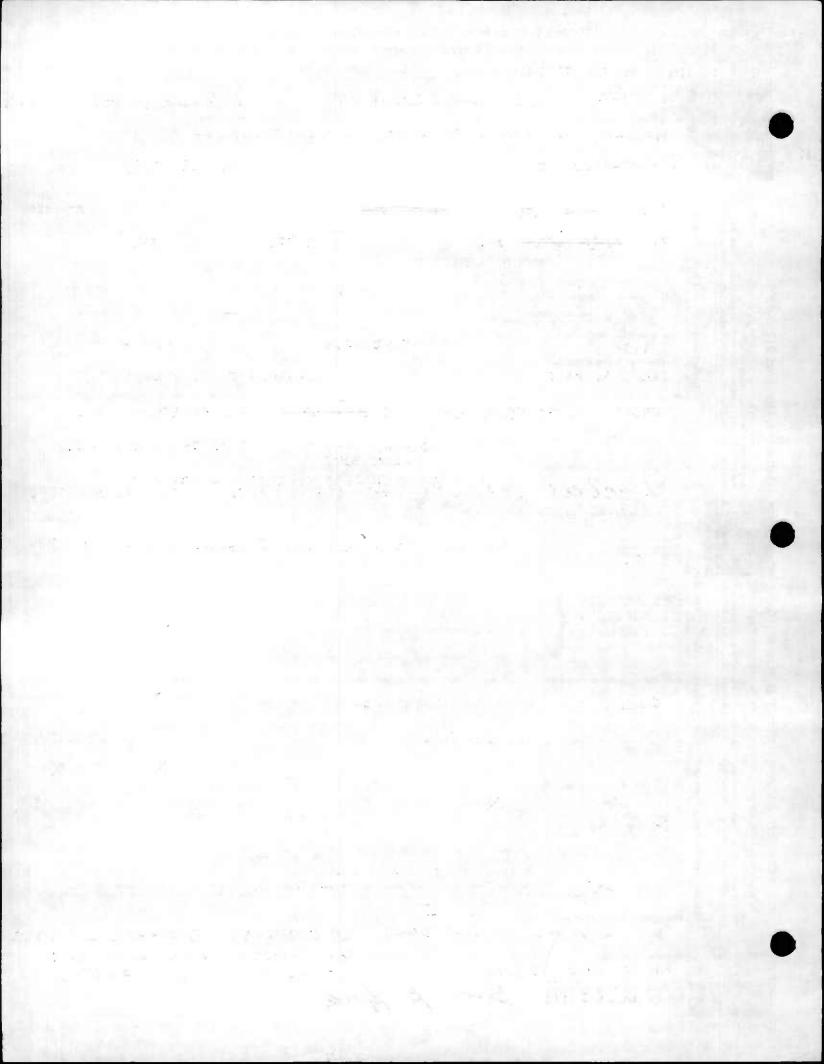
completed cause of death (Item 23a) (Type, Print) 300 / SOUTH 30. Name end eddress of person with SHWE MRA GYAN BALTIMORE

State Registrar

37 Registrar's Signature Darker!

DHMH 16 Rev 6/95

To the Hospital or within 24 hours aft To the Funeral DI completely filled in



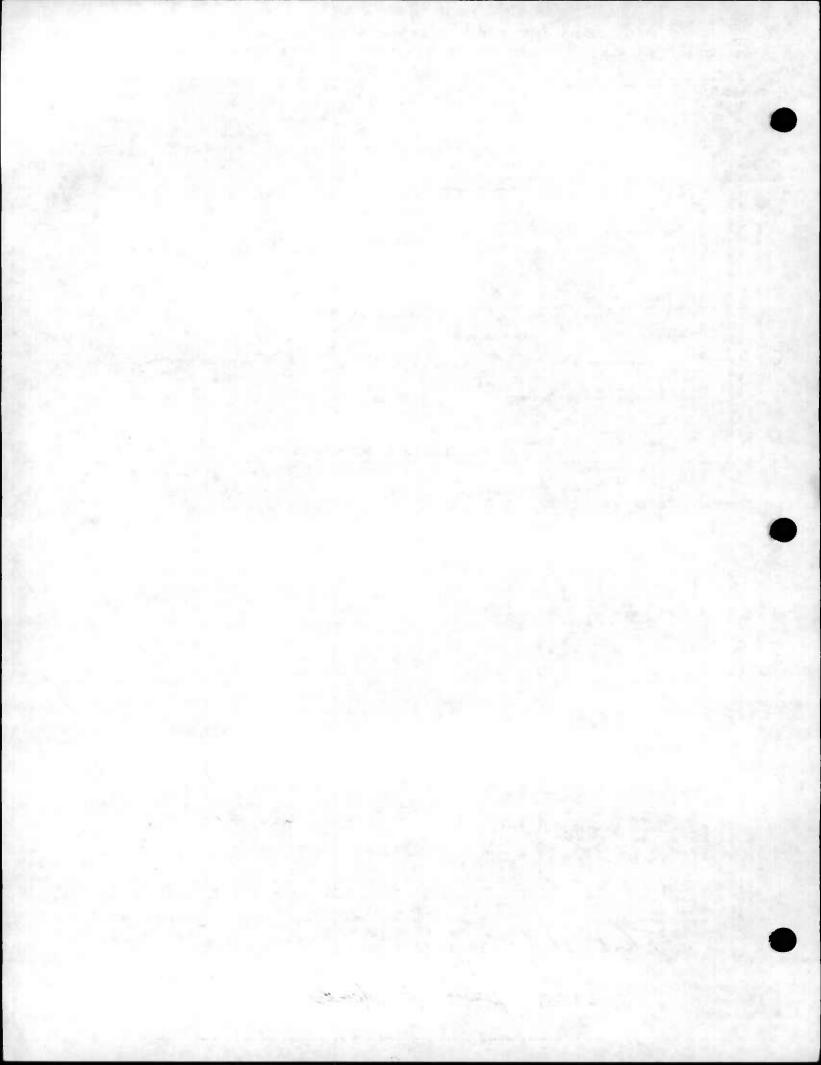
99-7772-0		Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene PART I, 27, 28A-F Certificate of Death 1, 2000 WR. Reg. No. 199								
				27,	28A-F	Certificate	of Death 200		i. No.	+0732
Physician /Medical	Decedent's Name (Fire	rst, Middle, La	,	Patr	ick Kyle	Murphy		2. Date of Death Month December	Day Year 25, 1999	3. Time of Death 7:03 A.M.
	4e Facility Name (If not				ber)		4b. City, Town, or L	ocation of Death	4c. County of Death	h
	1941 Feathe	erbed I	ane				Gwynn (Dak	Baltimo	ore

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

	216 94	7300	1 ⊠ M 2□ F	26	Yrs.	Months Da	ays Hours	Min. (Month, April	Birth Dey, Yeer) 22, 1973	Birthplace (State or Foreig Country) Maryland	
	10a. State	10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Limit	
ctor	Maryland	Baltin	nore	100	Baltin	nore				1 ☐ Yes 2X No	
Director	10a. Street and Nur					10f. Zip Coo		BY WE	10g. Citizen of V		
		atherbed	Lane	at Ever le 11	e 10		207	iain? (Snacity Vac or	U.S	e - American Indian,	
by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? ☑No		If Yes, specify (igin? (Specify Yes or n, Puerto Rican, etc.)	Specify	ck, White, etc.	
eted	(Spec	15. Decedent's E	ducetion ede completed)		16a. Dece (Give	dent's Usual Oc kind of work de DO NOT use re	ocupation one during mos	at of working	16b. Kind of Bo	usiness/industry	
Completed	Elementary/Seco 12th		College (1-4o	or 5+)		ndscapi			Lawn C	are	
To Be	17. Father's Name		Patrick E	. Murp	ohy		18. Moth	Vernale	a N. Murp		
	19a. Informent's Ne Pamela	Cronise	(Type, Print) / Siste		106	Weldon	Road		e, Maryla	and 21226	
			Removal from Sta	le C	emetery, cre	osition (Neme of metory or other Service	plece)	12/30/		City or Town, State	
	21. Signature of Fu		ramuce	uh		2. Name end A		^{ty} Gonce ghway Ba		Home P.A. Md. 21225	
	23a. Part1. Enter the shock, or hea	he disease, or con rt failure. List only	pplications that cause on each	ed the death	n. Do not en	ter the mode of	dying, such as	cerdiac or respirator	y arrest,	Approximate Intervat Between Onset and Death	
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	resulting in death)		a	Due to (o	r as a conse	quence of):					
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									les en eutopsy erformed?	24b. Were autopsy findings available prior to completion of cause of death?	
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Certification: To Be Completed by	examiner? 1 Yes 2 27. Manner of Deat 1 Natural 2 Accident 3 Suicide	No 5 Pending investigatic determined	28a. Date of Ir Found 1 12-2 28e. Place of building.	injury Dey Yeer) 5 = 9 9 Injury - At ho etc. (Specify st of my know	FOUNT 7:01 me, farm, st	of A 28c. M 28c. D M 28c. DENCE	Other: 4 No.	ursing Home 50 R 28d. Descri UNKN 28f. Locatio City or LANE	NOWN In (Street and Number 1988) Street and Number 1988 BALTI The cause(s) and m	per of Rural Route Number. 41 FEATHERB MORE, MD	
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edical Certification: To Be Completed by	examiner? 1 1 2 Yes 2 2 2 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one)	No 5 Pending investigatic 6 Could not to determined 1 Certifying Plant Medical Examples	28a. Date of Ir F OUND 1 2 28e. Place of building.	injury Dey Yeer) 5 = 9 9 Injury - At ho etc. (Specify st of my know	FOUNT 7:01 me, farm, st	of A 28c. Mereet, factory, off DENCE h occurred at the vestigation, in recognition of the control of the cont	Other: 4 N	ursing Home 50 R 28d. Descri UNKI 28f. Locatio City or LANI and place, and due to other	be how injury occur NOWN In (Street and Num) Town, State) E, BALTI the cause(s) and mine, date and place, 29d. Date signe	ber of Rural Royle Number, 241 FEATHERB MORE, MD anner as stated.	

State Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death MURPHY **Physician** . Q on A :10 80 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 4061 Lomar Drive Frederick Mt. Airy If Under 24 Hrs. 5. Social Security Number If Under 1 Yaar 8. Data of Birth (Month, Day, Year) August 12, 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M XXF 89 Yrs 084-09-1862 Director 1910 New Jersey Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentai Hydene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow any injury or other traumatic avant, the Medical Examiner must be noured at pine. 1 ☐ Yas 🎘 ☐ No Director Frederick Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4061 Lomar Drive Funeral 21771 14. Race - Amarican Indian, 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usuat Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years 18. Mothar's Name (First, Middle, Maiden Surmama) 17. Fathar's Nama (First, Middla, Last) John Hamley Eleanora Mary Wojtala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Carol Kozimor (Daughter) 4061 Lomar Drive 20b. Place of Disposition (Nama of cematery, crametory or other place) 20c. Location - City or Town, Stata 1)\(\sum_\)\(\text{Burial}\) 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Gertrude Cemetery 12/30/99 Colonia, New Jersey 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Witzke Funeral Home of Catonsville, Inc. Ca. Withke 1630 Edmondson Ave. Catonsville, MD Approximate totarval Batween Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart faiture. List only one cause on each line. **Physician** Immediata Causa (Finat diseasa or condition rasulting in death) /Medical 0 Examiner Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted physician and is the burial-trans Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury thet initieted events rasulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760. Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 ahould be detact 4 Unknown 1 ☐ Yee 2 ☐ No 3 ☐ Probably Be Completed by 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to complation of causa of deeth? 2 No certificate 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: funaral director, 25. Was casa refarred to medical 26. Place of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify)
Injury at 28d. Describe how injury occurred 1 Yas 2 TNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Dea 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending invastigation death. 2 Accident 1 ☐ Yas 2 ☐ No To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completaly filled in by the fi 6 ☐ Could not be detarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homtcide 10 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, end due to the ceusa(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceusa(s) and menner stated. 29a. Cartifier (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (tem 23a) (Type, Print) ower (AID Finelerick III 3,0 W. Stl me y 31. Data filed (Month, DEC 29 32. Registrar's Signatura State Registrar

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TCEIN IDD T	EN DVN 12/29/99 14			Certificate of	of Death	7	Re	g. No.	7	0104
Discordada	1. Decedent's Name (First, Mic	ddla, Last)					2. Data of Death Month	Day	Year	3. Time of Death
Physician /Medical	ISRAEL			MY	ERS		DECEMBER		1999	8:55 PM
Examiner	4a Facility Name (If not institu NORTH OAKS	THE RESERVE OF THE PROPERTY OF THE PARTY.				own, or Lo	CLE	4c. County BAI	y of Death	RE
Funeral Director	5. Social Security Number 215-07-3784	6. Sex 1 2 M 2 □ F	7. Age (In yrs. last birth	Months Da		Min.	8. Date of Birth (Month, Pay, APR • 12,	19 06	9. Birthp Cour	place (State or Forei
D .	Usual Residence of Decedent 10a. State 10b. Cour	ahv	10c. City, Town	nr Location						t0d. Inside City Limi
the Marylar 28a-f show notified at		BALTIMORE	Toc. Ony, Town		PIKES	VILLE				1 ☐ Yes 2 🖔 N
for death with the Mai r flows 23s or 28s-f a five mail be notified Funeral Director	10e. Street and Number 725 MT. WILS	ON LANE		10f. Zip Coo	21208		10	g. Citizen of U.S.A.		ntry?
V. V.	3 X Widowed 4 □ Divord	Armed F arried 1 ☐ Yes If Yes G	2 No	13. Was Decedent If Yes, specify €	Suban, Maxica	an, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White, fy:	
within then.	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Education hest grade completed	(1-4or 5+)	decedent's Usual Oc Give kind of work do ife. DO NOT use re NER & FOU	na during mo tired)	st of work	ring	6b. Kind of B		dustry
D Soft	17. Father's Name (First, Midd	le, Last)	MYI	ERS	18. Moth		e (First, Middle, M Blumens			STEIN
12 to	19a. Informant's Name/Relation JOHN MYERS /	onship (Type, Print) SON	196.1	Mailing Address (Str. 15 VELVET	eet and Numi	Y WA	ral Route Number, Y - OWING	City or Town	LS, M	Coda) iD 21117
	20a. Method of Disposition 1 Burial 2		State cemetery,	Disposition (Name of crematory or other MEMORIA	place)	1	Date 2 2/28/99	0c. Location RAND		own, State IOWN, MD
pemil. Pages Department of Important: If it any injury or phos.	21. Signature of Funeral Servi	ce Licensee		22. Name and Ad 8900 REIS		S	OL LEVINS			
	a. Part1. Enter the disease, shock, or heart failure. L	or complications that	caused tha death. Do no						 	Approximata Interval Batween
Physician /Medical Examiner	Immediate Causa (Finat disease or condition resulting in death)	a. C	Due to (or as a co	nsequence bi):	avres	f			1	Onset and Death
artificate be executed sing physician end se as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):									
nding use a	resulting in death) Last Parking on J dikak									
the day	Part II. Other significant cond	itions confributing to d	leath but not resulting in t	he underlying cause	given in Parl	1 I.	23b. Did tob	ecco use co		o the cause of deat
igned by be detected by Phy							1 Ye	2 2 No	3 Pro	bebly 4 Unkno
> H = -		Way.		. 3			24a. Was an perform		av	fera autopsy finding vailable prior to empletion of cause daath?
The lew ate has b pege 2 a Comple							1 ☐ Yes	2 10 No		□Yas 2□No
certificate rector, per	25. Was case refarred to medi	cal			26. Plac	ca of Deat	th (Check only ons			
Z 0 0	examiner?	Hospital:	Inpatient 2 ER/Outp	atient 3 DOA	Other		ome 5 Rasidar		har (Specil	fy)
e Hospital or Attanding Ph. 24 hours after death. Puneral Director. After th. pietely filled in by the funeral edical Certification: 7	27. Manner of Death 1) Natural 5 Pen 2 Accidant inve	ding stigation	of Injury 28b. Tir th, Day Year) Inju		njury at Work? 1 🗌 Yes 2		28d. Describe how			
rs after d at Direct ed in by Certific	3 Suicide 6 Cou	mined 200. Flac	e of Injury - At home, fam ling, etc. (Specify)	n, street, factory, off	ice		281. Location (Str. City or Town,	eet and Num State)	ber or Run	al Houte Number,
To the Hospital or within 24 hours after To the Funeral Direction Completely filled in Medical Cert	29a. Cartifier 15 Certification (Check only one) 15 Certification 15 Certi	al Examiner: On the b	a best of my knowledge, on a best of examination and/oner stated.	death occurred at the or investigation, in re	e time, data a ny opinion, da	nd placa, ath occur	and due to tha ca red at tha time, da	usa(s) and m te and placa,	anner as s , and due to	itated. o the cause(s)
To the company of the	29b. Signature and file of certi	fier	IM	29c. Lic	30	339	29	d. Date signe	ed (Month,	Pay, Year)
0	30. Name and addrass of person	on who completed cau	se of death (Item 23a) (T	ype, Print) 1000 (Xd (Conv	+ na;	Ball	mpri	nour
State Registrar	31. Date filed (Month, Day, Year DEC 2 9 10		Régistrar's Signature	Sparks	/					100

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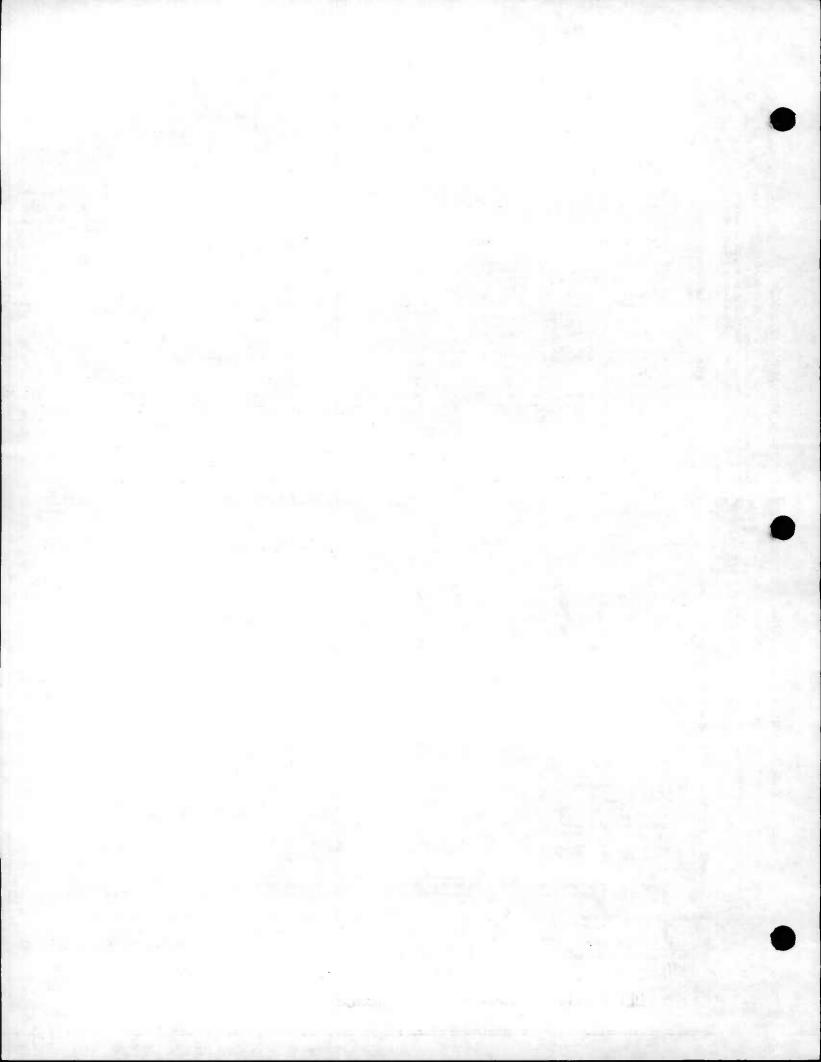
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** DECEMBER 26, 1999 BERTHA NOAH 3:34 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT & NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1□ M 25 F Yrs. 215-58-0425 Director 82 OCT. 3,1917 EGYPT Usual Rasidance of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yas 2 X No BALTIMORE BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3940 SOUTHERN CROSS DRIVE 21207 U.S.A. 238 Funeral or items 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 XNo If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. Black, Whita, atc. filed within 72 hours efter 1 Nevar Married 2 Married 21215-0020 1 Ves 2 No Specify: WHITE à 3 X Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER parmit. Peges 1 and 2 should be filed w
Department of Health and Mentel Hygies.
Important: if item 27 is marked other the
eny injury or other treuments. OWN HOME Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 2 **ANGELO** NEGRIN STMCHA (UNKNOWN) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUES NOAH / SON 12210 PARKHEIGHTS AVENUE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 12/28/99 OWINGS MILLS, MD HAR SINAI CEMETERY 21. Signatura of Funarat Sarvice Liger 22. Name and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Batween Onset and Death **Physician** Immediata Cause (Final diseasa or condition rasulting in daath) /Medical Examiner Liver The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disaase or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 8 24b. Were autopsy tindings available prior to complation of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yas 2 ☐ NO 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: 25. Was casa ratarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division After 5 Panding invastigation To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: Afte completely filled in by the fun 1 Watural INJURG 1 Yes 2 No 2 Accident No 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifian (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) Risterdan 2 9 1999 420 25 Mar 32 Registrar's Signature Main

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 815 pm RUTH MYERS PAYNE 1999 December 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) BALTIMORE N/A UNION MEMORIAL HOSPITAL
Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)
11- 22-1923 Birthplece (Stete or Foreign Country) Months Deys Hours Yrs 212 20 3150 76 MD Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21218 3826 KIMBLE RD. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Merital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify BLACK Specify: 3€Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) ARTHUR W. MYERS MATILDA HODGES 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) SHARON J. STEWART /NIECE 4020 THE ALAMEDA BALTO., MD. 21218 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a, Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removel from State 1/03/00 CEDAR HILL CEM BALTO., MD. 4 Donetion 5 □ Other (Specify) 21. \$igneture of Funeral Service Licensee 22 Name and Address of Eacility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217 Approximate Intervel Between Onset end Death ung cancer year Due to (or es e consequence of): Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed?)ementra

Physician Avicaica Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, he Medical Examinet must be rout and anonce.

3altimore, Maryland 21215-0020

with the Maryland

as the bunal-trar 8 director,

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examiner ed by the attending physician detached for use as the buna peubis peen this certificate funeral After t

by Completed Be 2

Physician/Medical Certification:

ours after dean.

• Director: At.

In by the fur-To the Hospital o within 24 hours af To the Funeral Di completely filled I

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

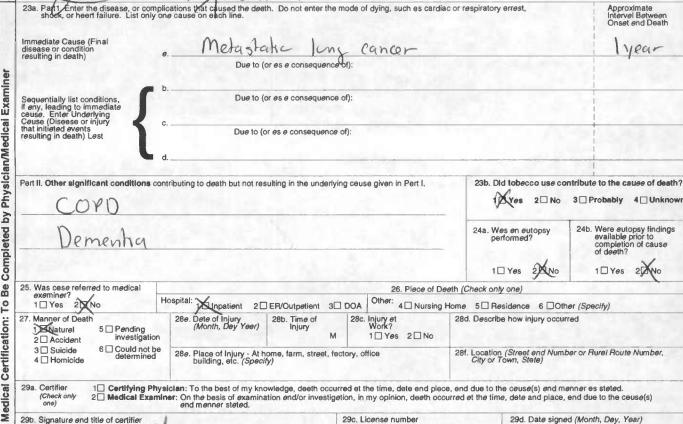
Union Memoran

32/Registrar's Signeture

Harnson Johnson MD

DEC 2 9 1999

31. Date filed (Month, Day, Year)



2438946

December 27, 1999

201 East University Parkway Ballimore MO 21818

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician VERNON** PHILLIPS 10:12 AM DECEMBER 1999 /Medical 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Deeth **Examiner** Baltimore Hospital Agnes 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2DF Months Deys Hours 220-20-0360 Maryland Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Arbutus Director 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1227 Birch States 21227 Inited Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 BYes 2 No 1/1 0/195/ 179s, Give Year or Dates: 10/10/1952 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, 11. Maritel Stetus permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or item any injury or other traumatic event, the Mental Exercities. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
iffe. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surneme) -Be Marie Gaylord Thillips ohn 19e. Informent's Name/Reletionship (Type, Print)
Mary Phillips / Wit 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1227 Birch Arbotus MD 21227 20e. Method of Disposition

1 Burial 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Crounsville Maryland MD Veterans Cemetera 21. Signature of Funchal Service Licensee

22. Neme end Address of Fecility Ambrose Funcial Howe, The

1338 Sulphus Spring Ro Balto Mi 21237

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximately approximate Physician EMPHYSEMA /Medical immediete Ceuse (Finel diseese or condition resulting in deeth) 10 yrs **Examiner** Examiner ig physician and as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown á 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes 2 No After this certificete To the Hospital or Attending Physician: within 24 hours after death.

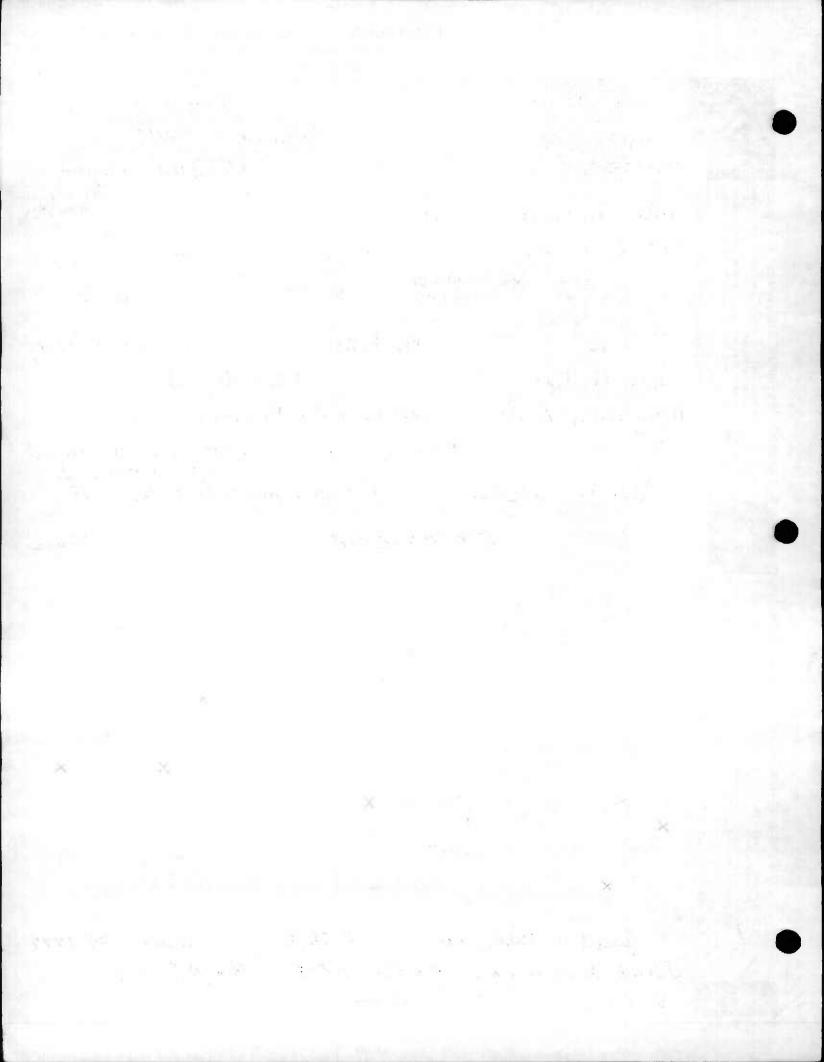
Fo the Funeral Director: After this certifice 25. Was cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. fnjury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 🛣 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of School 19 Joseph H. Miller MD 100782

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

900 CATON AVE Baltime, Mcl. 21229 December 24, 1999

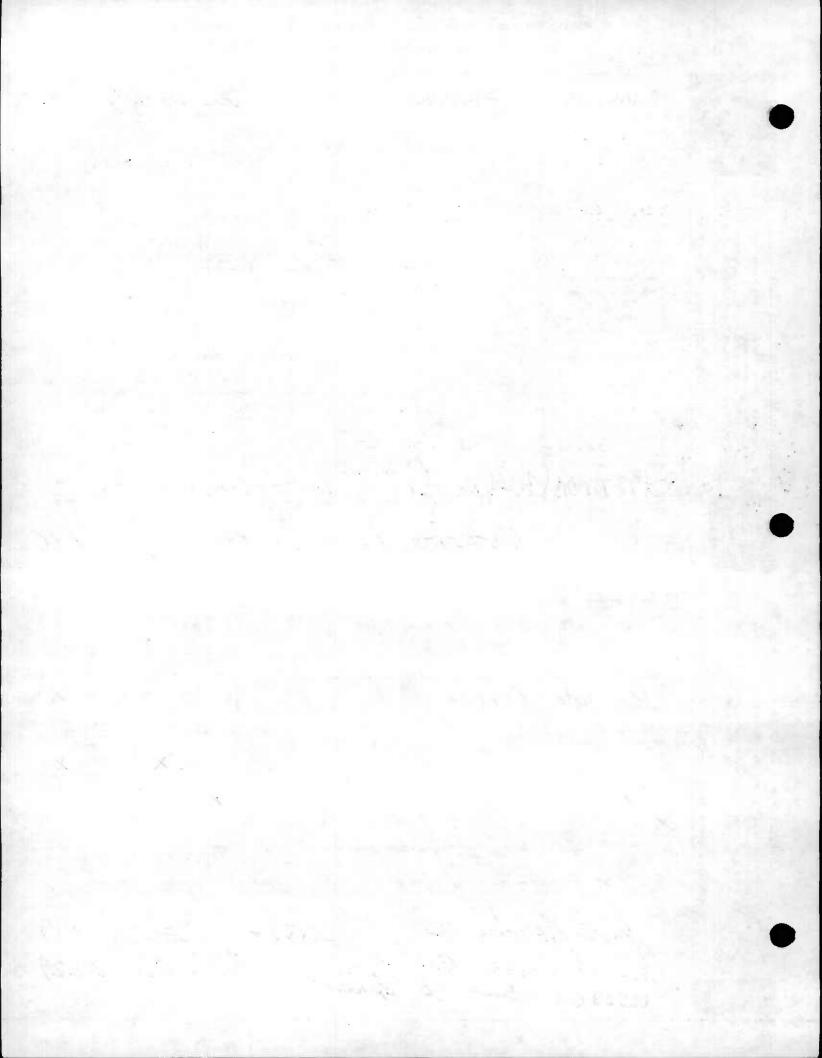
DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of			Reg. No.	9 40738			
Physician	1. Decedent's Neme (First, Middle, Las		0			2. Date of De Month	Day,	3. Time of Death			
/Medical	CHARLES	PRYC)K		41 Ch. T.	DEC	24 19	99 11:23 19.11			
Examiner	4e Facility Name (If not institution, give	street and number)			3 - 12 11 11 11 11	Location of Deat					
5	3421 Jay Drive 5. Social Security Number 6. Se	x 7. Age (In yrs	last hirthria	The second secon	Ellicott		Howar				
Funeral Director		DM 2₽F 83	Yrs.	Months Days	Hours Min	(Month, De	Birth (State or Foreign Country) 11, 1916 Baltimore				
	Usuel Residence of Decedent										
anylar ahow	10e. State 10b. County		ity, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
vith the Ma t or 28a-f a be notified	Maryland Howard	E1.	Licott								
atter death with the Manylar or items 23s or 28s-1 show more must be notified at	10e. Street and Number 3421 Jay Drive			10f. Zip Code 2104			10g. Citizen of What Country? U.S.A.				
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s-1 show alsal Examine must be notified at sted by Funeral Director	11. Marital Status 1 Never Merried 2 Merried 3 Vidowed 4 Divorced	TALIYOS ZI INO	7.5. 740 745	3. Wes Decedent of H If Yes, specify Cubs 1 Yes 2 No	lispanic Origin? (! an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: White				
- s - 5	15. Decedent's Edi (Specify only highest gred Elementery/Secondery (0-12)		16a. Dec (Gir life	edent's Usual Occup re kind of work done of DO NOT use retired	ation during most of wo	orking	16b. Kind of Bu	siness/Industry			
d 212 filed with Hygiene. ther than and, trees	11		Sale	S			Ind	ustrial Fencing			
and	17. Father's Neme (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Sumam	θ)			
arylan should be and Mentel marked o umatic ava	Wachter Dean Pryc		_			Dorothy					
C = 0 =	19e. Informent's Name/Relationship (T) Douglas Pryor, Sc			iling Address (Street 1 Jay Driv				State, Zip Code) 21042			
ges 1 en t of Heal If Itam 2 or other	20e. Method of Disposition		Place of Dis	position (Name of rematory or other place	xe)	Date	20c. Location -	City or Town, State			
E & Se Hit Z	1 XBuriel 2 Cremation 3 4 Donetion 5 Other (Specify,		Loudo	n Park		12-29-99	Arbutu	s, MD			
Baltimore, permit. Pages 1 a Department of Her Important: If Itam any Injury or othe	21. Signature of Funeral Service Licens	neday.	11	22. Name and Address Ambrose Fu	ineral H			MD 21227			
	23e. Pert1. Enter the disease, or don't shock, or heert leilure. List only o	scations that clused the dee						MD. 21227			
Physician /Medical Examiner	Immediete Ceuse (Finel disease or condition resulting in deeth)	METASTI	TIC or es e cons	LUNG	CAN			Intervel Between Onset and Death			
nsit miner		b	40/2/200								
(68760, rifficate be executed ng physician and as the burial-transit Aedical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.										
O	Due to (or as a consequence of):										
Box deeth cert attendin d for use	Pod II Other significant acaditions co	atabutian to death but not a	andrew in the s	under the name of the	an in Dani	non Did	1 - 1	tribute to the cause of death?			
D	Part II. Other significant conditions con Prostate	Cancer	suiting in the	underlying cause giv	en in Parti.						
The law requires that The law requires that sate has been signed b page 2 should be det Completed by Pl						24a. Wes	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?			
The law rate has page 2						10	Yes 2000	1 ☐ Yes 2 1 No			
sician: The certificate lirector, pag	25. Was case referred to medical				26. Place of De	ath (Check only	one)				
Of VItal Physician: this certific ral director,	examiner?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpati	ent 3 DOA Oth	er: 4 Nursing	Home 5 Pagesi	dence 6 Othe	er (Specify)			
n Of ng Phyr tter this meral d	27. Menner ol Death 1 Naturei 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		y at k?	28d. Describe	how injury occurr	ed			
Attanding r deeth. Ctor: After by the fune iffication	2 ☐ Accident investigation				Yes 2 □ No						
DIVISION C bal or Attanding P is after deeth. at Director: Aftert led in by the funers Certification:	3 Suicide 6 Could not be determined	street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
ne Hospi n 24 houns ne Funer pletely fill edical	29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only ene) Check only ene) Check only ene)										
To the Within	29b. Signature and title of conflier	senly no	D	29c. Licens	isss:	7	29d. Date signed	(Month, Day, Year) 24 1999			
V	30. Name and address of person who co	ompleted cause of death (the	n 23a) (Type			BAUT		212.79			
State Registrar	31. Date liled (Month, Day, Year) DEC 2 9 1999	82 Registrar's Sign	atures ,	CATON Sports	110						
DHMH 16 Rev 6/95	220	7									



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	1	. Decedent's Name (First, Middle, Las	st)		OGITIN	cate of		2. Data of Daat	ng. No.	3.	Time of Death		
sician		11	*	PR	ATT			Month	Day	Yaar	2:05 AM		
edical miner	4	HOWARD PRATI December 21, 1 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County									2.05 AF		
IIIIICI	н	Charlestown Reti			itv		Baltimore		,	Balti	more		
al	5	. Social Security Number 6. S	ex 7. A	ge (in yrs.	iast birthday)	Inder 1 Year	and the last terminal and the last terminal and the	B. Date of Birth (Month, Day,	Vacal		(State or Foreig		
or		217-03-4091 1 Usual Residence of Decedent	₩ 2□ F	94	Yrs.	ths Days	Hours Min.	Iay 27,	1905	MA			
	1	10a. State 10b. County 10c. City, Town or Location								10d. Ir	side City Limit		
Director		MD Baltim	ore	Ва	altimore					1	☐ Yes 21 N		
Director	10e. Street and Numbar 10f. Zip Code							10	Og. Citizen of \	Whet Country?			
2		709 Maiden Choice	Lane			212	228		US	SA			
by Funeral		1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Dacadent Armed Forces' 1 Yes 2X If Yes, Give Year or Dates:	?		ecedent of F specity Cub es 2X No	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	lfy Yes or No- ican, etc.)	Blac	e-American Inck, White, etc. white	dian,		
te d		15. Decedent's Ed	ucation		16a. Decedent's	Usual Occup	petion		16b. Kind of Bi	usiness/Industry			
injury or other traumatic event, the Medical Ext.	-	(Specify only highest gra	College (1-4or	5+)	(Giva kind of work done during most of wo life. DO NOT use retired)			9		The London			
		12 7. Father's Neme (First, Middle, Last)	0		Sale	sperso		ame (First, Middle, Maiden Sumame)					
		The state of the s		18. Mothers Name (rirst, Middle, N	naiden Suman	16)						
	-	Dwight Pratt			T		Emma La						
		9a. informant's Name/Relationship (1	ype, Print)			300	and Number or Rura!			State, Zip Code	9)		
	-	David Pratt/son Oa. Method of Disposition		20h D	6003 I	akehui	rst Drive I	Baltimo	re, MD	21210	14-4-		
		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif)	1	C	ametery, crematory	or other ple				City or Town, S	stete		
SUCE	State And State on												
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Medicai	1	Cause (Disease or Injury hat initiated events asulting In death) Last	Due to (or as e consequenca of):										
Physician/	P	art tt. Other significant conditions co	ontributing to death b	out not resu	ulting in the underly	Ina cause aix	van in Part I	23b. Did to	bacco use co	ntributa to the	sause of death		
y Phys									2 No	3 Probably			
Completed by	-								n autopsy ned?	evelleble	4b. Ware autopsy findings evelleble prior to completion of cause of daath?		
mo								1□ Ye	s 200 No	1 □ Yes	2 No		
	2	5. Was case referred to medical					26. Place of Death			, , ,	-		
Medical Certification: To Be Co		examinar?	Hospitel: 1 ☐ Inpati	ent 2	ER/Outpatient 3[DOA Oth				er (Snecify)			
	2	7. Manner of Death	28a. Date of Inju (Month, Da	28b. Time of Injury	28c. Injur Wor		28d. Dascribe how Injury occurred						
		1, ☐ Natural 5 ☐ Pending investigation	Yes 2 □ No	□No									
completely filled in by the funerance Medical Certification:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ertif	1	29a. Cartifier Check only 29 Medical Examinar: On the basis of examination and/or investigation, in my opinion, dath occurred at tha time, date and place, and due to the cause(s) and mennar as stated.											
	2		(Check only one) Check										
Medicai Certif		(Check only 2 Medical Exam	inar: On the basis of	ated.		29c. Licens	se number	25	d. Date signe	d (Month, Day,	Year)		
edicai		(Check only 2 Medical Exam	inar: On the basis of	ated.	1,0,	04	4748	D	ECEMBE	En 21	,1999		
edicai	2	(Check only 2 Medical Exam	iner: On the basis of and manner st	ated.	1 , D , 23a) (Type, Print)	04		D	ECEMBE	En 21	,199		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Alene Phyllis Paddock 6:20 AM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Name (If not Institution, give street end number) Lorien Nursing Home | Columbia | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | (Month, Dey, Year) Howard 5. Sociel Security Number Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) Months 440-24-0104 September 26, 1918 Colorado Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 21044 10372 May Wind Court U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Airy Lasker Snelson Pearl Ellen Collinsworth 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Daughter 10372 May Wind Court Columbia, Maryland 21044 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) Dete 20c. Location - City Mrs. Linda McGee Daug 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) 20c. Location - City or Town, Steta All County Cremation Services, Inc. 12/29/1999 Sykesville, Maryland 21. Signature of Funeral Sarvige Licens 22. Name end Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043. Ellem lette. MO0538 23e. Part 1. Enter the disease, or complications that causad tha daath. Do not enter tha moda of dying, such as cardiac or raspiretory errast, shock, or heer feilure. Lift only one ceuse on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) blume's deme Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to completion of causa of deeth? 24a. Wes en eutopsy performed? BRAYNONL 2 No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

þ

Completed

Be

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Exampler must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Fernis

Baltimore, Maryland 21215-0020

physician and s the burial-trensit Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Be Completed by

Medical Certification: To

27. Manner of Deeth

1 Netural 2 Accident

3 ☐ Suicide

29a Certifier

4 Homicide

29b. Signeture end title of certifier

efter death.

or Attending Physician: To the Hospital of within 24 hours of To the Funeral D completely filled in

> State Registrar

OHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

30. Name end addrass of person who completed cause daath (Itam 23a) (Type, Print)

9

DEC 2

5 Pending

Investigation

6 Could not be determined

9501

32. Registrar's Signeture

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

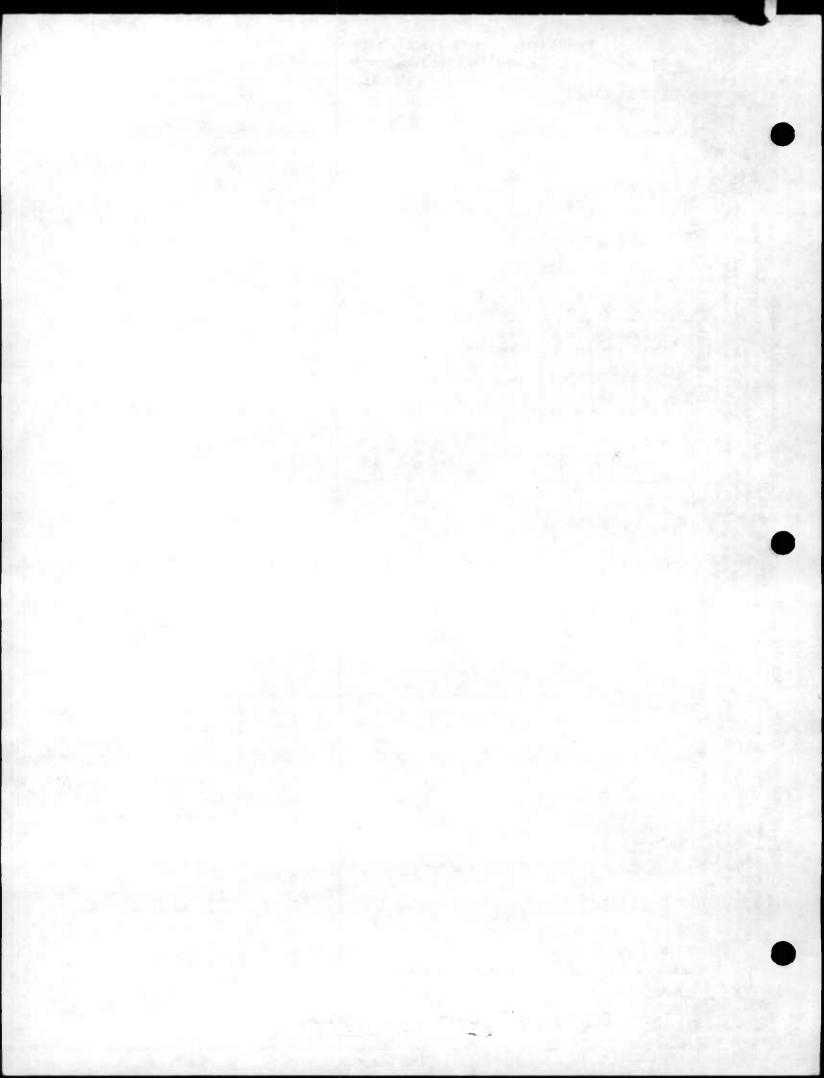
29c. Licansa number

1 Yes 2 No

29d. Dete signed (Month, Day, Year)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Steta)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Dec. . 1999 ear **Physician** 22, 4:00p.m. David L. Pallett, Sr. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2825 Lodge Farm Rd. Edgemere Balto. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 231-26-9228 1₽M 2□F Months 70 Yrs. Director July 28,1929 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show traumetic event, the Medical Examiner nust be notified at Md. Baltimore Edgemere 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 U.S.A. 21219 natural', or items 23s 2825 Lodge Farm Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Stetus Black, White, etc. e filed within 72 hours after all Hygiene. Other than "natural", or he 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify.White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Cabinett Maker Woodworking 10 permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Itam 27 Is marked other any Injury or other traumatic event bace. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Elsie Mae Clayton David L. Pallett 19a. Informent's Neme/Relationship (Type, Print) Daughte 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Hilda Pallett/ in-law 2011 Barry Rd., Balto., Md. 21222 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Balto-Wash Crematory 12-24 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Laurel.Md. 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility Bradley-Ashton-Matthews Funeral Home, In 2134 Willow Spring Rd., Balto., Md. 21222 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 5 min Myocerdia Examiner O Due to (or es e consequenca of): Coronary Anterry ettending physician end for use as the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es)e consequenca of): P.O. Box 68760, Physician/Medical Due to (or es a consequença of) 23b. Did tobacco use contributa to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 □ Yes 2 □ No certificate To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of injury 28d. Describe how injury occurred 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated. 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. dicai 29a. Certifie (Check only one)

M

State Registrar

31. Date filed (Month, Dey, Yeer) DEC 2 9 1999

William

29b. Signeture end title of certifier

ma

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signeture books

CM-

DHMH 16 Rev 6/95

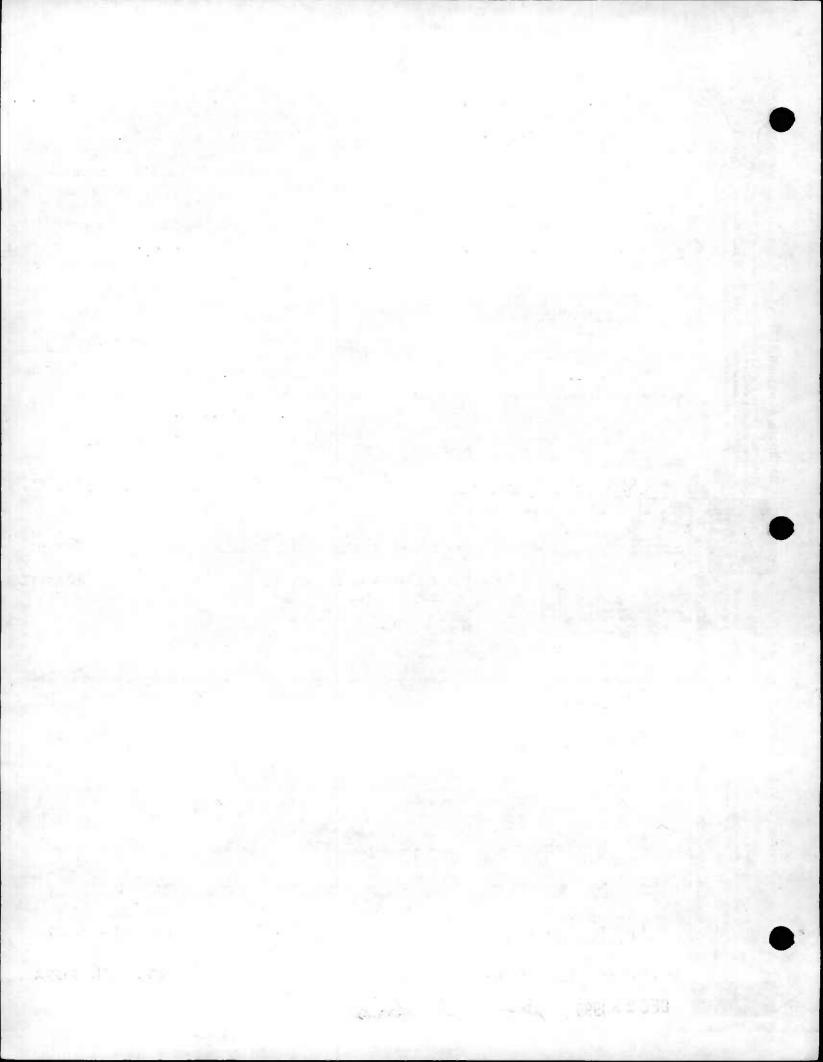
29c. License number

D50835

1576 merritt Blvd. Bultimore MD 21222

29d. Date signed (Month, Dey, Year)

12-32-1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth Month **Physician** Mary Louise Price 12 13 1999 /Medical 3.10pm4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 404 Montrose Avenue Catonsville Baltimore 5. Social Security Number If Under 1 Year Months Deys 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Months Hours Director 578-40-0917 02 25 1911 MD Usual Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21228 USA 404 Montrose Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedant Ever in U,S. Armed Forces? 14. Reca - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiane. Elementery/Secondery (0-12) College (1-4or 5+) Real Estate Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be f nant of Haalth and Mental I int: If itam 27 is marked of Lovell Figgins Harry C. Smith 19e. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 406 Patleigh Road, Baltimore, Md. 21228 Joan Bannon,Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Quriel 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Crest Lawn Mem. Gardens 12/16 Baltimore, Md. 21. Signature of Funerel Service Licanse 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue, Balto, Md. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. **Physician** Immediate Ceuse (Finel disease or condition rasulting in death) /Medical Examiner Duelo (or as e consequance of): The law requires that the death certificata be executed Physician/Medical Exami ician and burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Records, P.O. Box 68760, attanding physician for use as the buria Due to (or es e consequença of) been signed by the should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert it. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en eutopsy completion of causa of deeth? page 2 s certificate has 1 ☐ Yes 3 No 1 Tes rs after deau...
ral Director. After this ceru...
in by the funeral director, pr Division of Vital or Attanding Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home SPResidence 6 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completaly filled tsaccentifying Physicien: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner steted. 29e. Certifier Medical one) 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30 Neme, end eddres cause of death (Item 23a) (Type, Print) 7/6 Morde

32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

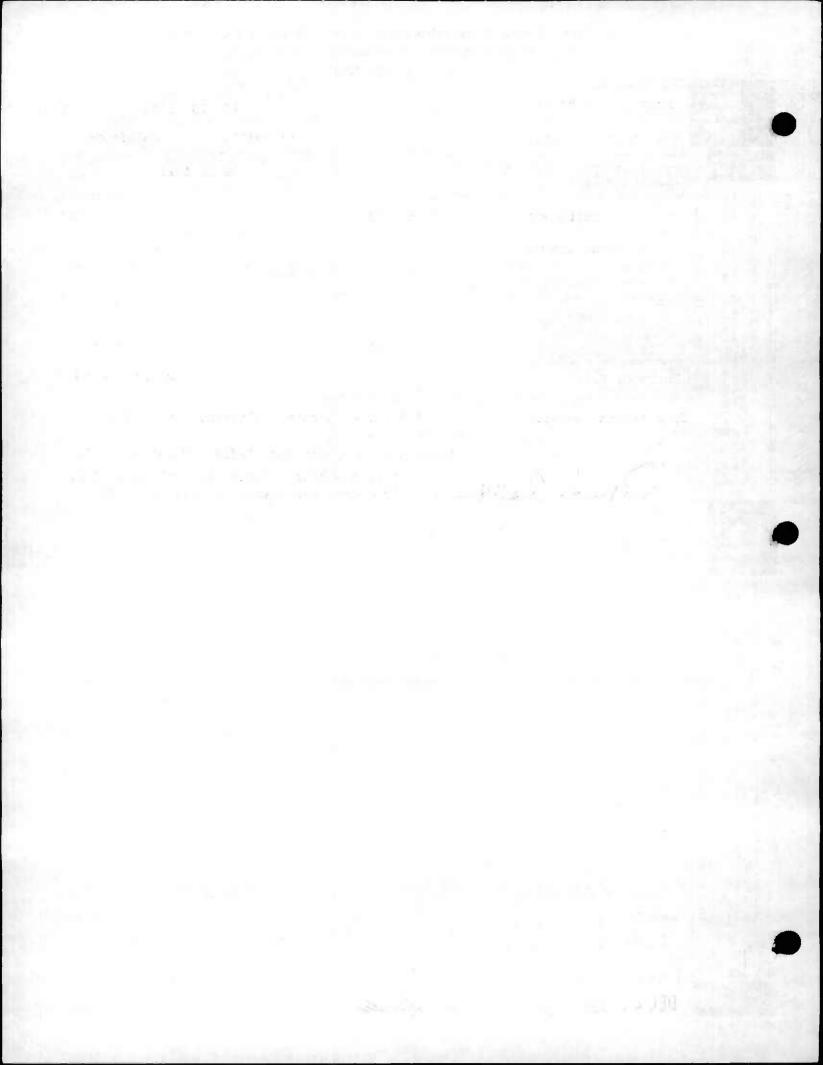
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State

Registrar

31. Dete filed (Month, Day, Year)

DEC 2 9 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Rosemarie M. Phillips December 26, 1999 1:00 p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3508 Langrehr Road Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 216-32-3274 66 Yrs. **Director** Sept. 28, 1933 Maryland Usual Rasidence of Dacedant 10a. Stata 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show N/A Md. Baltimore City 1 M Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2624 St. Paul Street 21218 United States natural, or itema 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours efter Hygiene. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Detes: 2 3 ☐ Widowed 4 💆 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Writer - Editor U.S. Gov't. 12 other permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Jujury or other traumatic event any Jujury or other traumatic event ansa 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew J. Marsiglia Marie Madden 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian M. Phillips (Son) 303 Rose Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Ramoval from Stata New Cathedral Cemetery 12/30/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Lidensee Milton J. Knight Jr 22. Nama and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Cause (Final disaasa or condition rasulting In deeth) /Medical (Uma) Examiner Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed A hours after death.

24 hours after death.

Parenal Director: After this certificate has been signed by the attending physicien and siely filled in by the funeral director, page 2 should be deteched for use as the burish-transit attending physicien and for use es the burial-trans Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Dua to (or as a consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 7No 3 Probably 4 Unknown Records. ρ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa rafarrad to medical 26. Place of Death (Check only one) Caregiver axaminar? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Residence 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? **D**Natural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only

Registrar

29b. Signature and title of the

Stanley 31. Data tiled (Month, Day, Year)

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Walker

DEC 2 9 1999

DHMH 16 Rev 6/95

3333 N. Calvert Street

32/Registrar's Signature

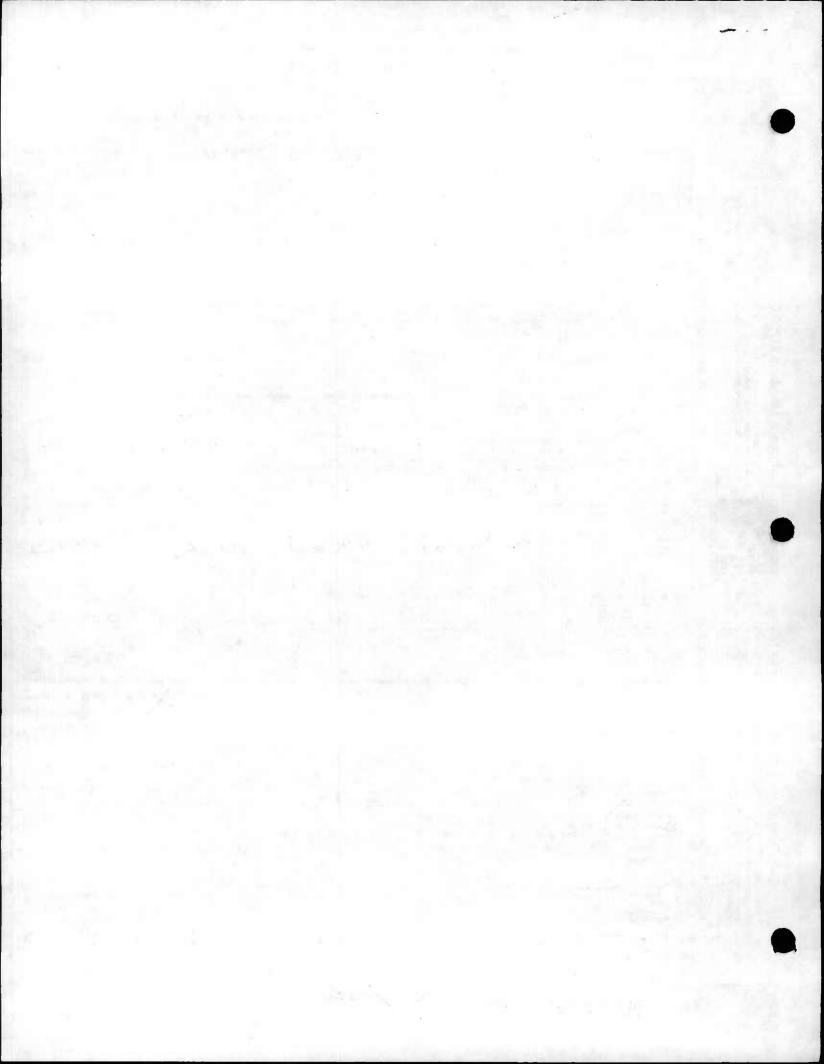
29c. License number

Suite

107

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21218



Physician

/Medical

Examiner

Funeral Director

Completed by

To Be

Physician/Medical Examiner

Completed by

Be

Certification: To

Medicai

3 Suicida

4 Homicida

Funeral

Director

Please	Type or F	Print in E	Black In	delibl	e ink.	Assu	re Al	I Copies	Are Lec	nible.			
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4a Facility Nama (If not institution, gir	va street and num	iber)			4	b. City, Tow	m, or Lo	ocation of Death	1 4c. Coun	nty of Death	h		
Greater Baltimo						Tows				ltimo			
	Sax 1½∏ M 2□ F	7. Aga (In yrs. I	last birthday) Yrs.	Months	Pr 1 Yaar Deys	If Undar 2 Hours	Min.	8. Data of Birl (Month, Da 05-02			Birthplaca (Stata or Foraign Country)		
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10e. Street and Number				10f. Zir	p Coda				10g. Citizen o	of What Co	untry?		
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11. Marital Status	12. Wes Deced	cas?	,S. 13.				in? (Spe Puarto	ecify Yes or No Rican, atc.)			rican Indian, a, etc.		
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(Specify only highast gr Elemantery/Secondary (0-12)	Collaga (1~	-4or 5+)	lifa.	DO NOT u	ise retired	during most of	Of WORK	ng	Indian Head Gap				
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A CONTRACTOR OF THE CONTRACTOR	" hardsor	n, Sr.				Fanr		(1	Richa		n		
19a. Informant's Name/Ralationship	(Type, Print)		19b. Maili	ing Addras	s (Street	and Numbe	r or Rura	al Route Numbe	ar, City or Tou	vn, Stata, Z	itata, Zip Coda)		
Vivian Richa	rdson		1335	5 Per	ntwo	od Ro	oad	Balt	imore	Mar	vland9.		
20a. Mathod of Disposition		20b. P	Place of Dispo	osition (Na	ıma of			Deta	20c. Location				
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	Y - C+		or as a consec										
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causa. Entar Undarlying Causa (Disasas or Injury that Initieled avants rasulting in daath) Lest	C	Due to (or	or as a conseq	quance of):									
	0									i	/		
Part II. Other significent conditions	contributing to dea	ath but not rasi	ulting in the u	indarlying (causa giv	an in Part I.					to the ceuse of deeth?		
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								1 🕅	Yas 2□No		1 ☐ Yas 2 ŽLNo		
25. Was casa rafarred to medical						26. Placa	of Deat	h (Chack only o	ona)				
axaminar? 1 ☐ Yes 2 ☒ No	Hospital:	npatiant 2	ER/Outpatier	ent 3 DC	OA Othe	or.		ma 5 Rasio		Other (Spec	cify)		
27. Menner of Death 1 ⊠Natural 5 □ Panding	28e. Dete of (Month		28b. Time o		28c. Injun Work			28d. Dascribe			Sily,		

In the Heaptial or Attending Physician: The law requires that the deeth certificate be executed within the table death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detected for use as the buriet-transit

Physician /Medical

Examiner

Division of Vital Records, P.O. Box 68760,

29a. Certifiar (Check only one) tto Certifying Physicien: To the best of my knowladga, daath occurred et the tima, deta and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the bests of axaminetion end/or invastigation, in my opinion, daeth occurred et the tima, date and place, and dua to tha causa(s) and manner statad. 29b. Signature and titla of certifia

29c. Licansa number

29d. Date signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

6 Could not be detarmined

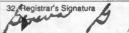
D38352

12/20/99

30. Nama end addrass of parson who completed causa of death (Itam 23a) (Type, Print) Beth R. Schwartz, M.D.

Greater Baltimore Medical Center 6701 N. Charles St., Baltimore, MD 21204

State Registrar 31. Dete filed (Month, Day, Year) DEC 2 9 1999



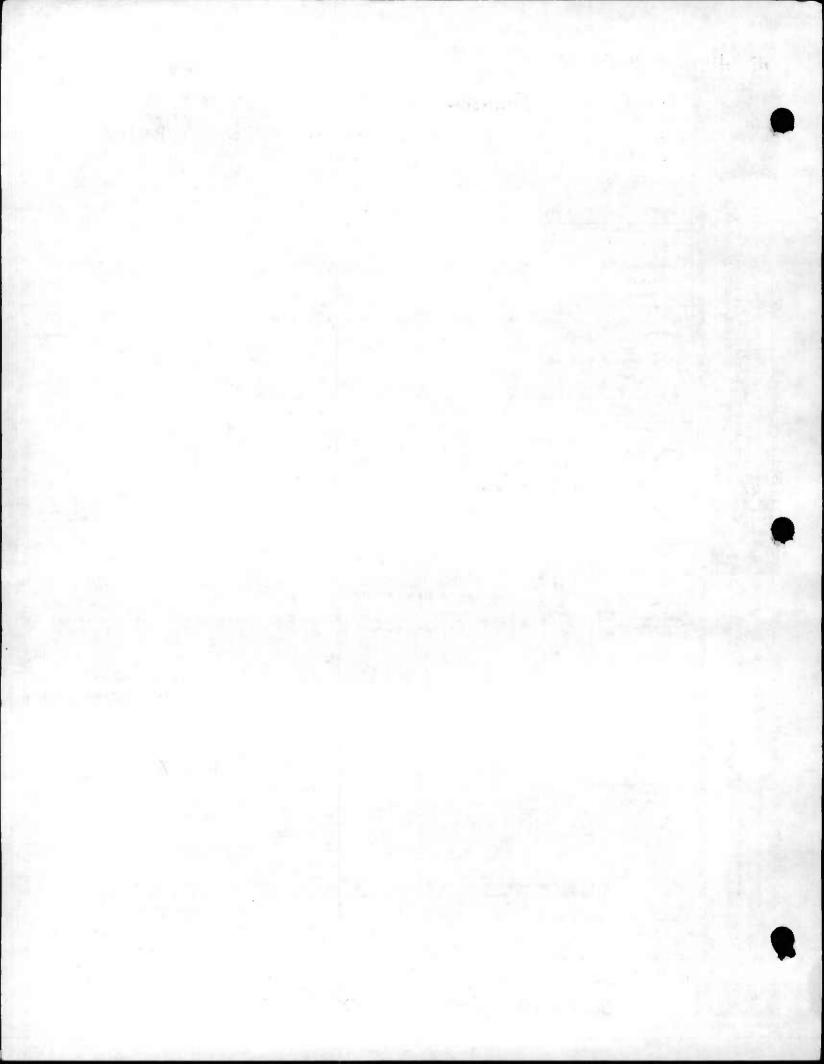
28a. Plece of Injury - At homa, ferm, straet, factory, office building, afc. (Spacify)



THE STREET

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Ball Manual Manu	(21. Signature of t	Funaral Service Lic	Morton				MORTON	& SONS T. BALTO				
Physician		23a Part Ente	r the disease, or co eart failure. List on	mplications that cau ly one cause on aac	sed the deat h line.	h. Do not ent	er the mode of dy	ing, such as card	diac or raspiratory	arrest,	Approximata Intarval Batween Onset and Daath		
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		resulting in death	,			or as a consec			00000		24 110.8		
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DIVISION To the Hospital or Attending I within 24 hours after death To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only	10 Certifying F	Physician: To the be aminer: On the basis and manner	s of axamina	wledge, death tion and/or im	n occurred at the ti vestigation, in my	ima, data and pli opinion, death o	ace, and dua to th courred at tha time	a cause(s) and ma a, data and place,	innar as stated. and dua to tha cause(s)		
To the To the comp	W	29b. Signature an	ditte of certifier	mo MEDI	CA1	thisest	29c. Licen	se number	000	29d. Data signed	d (Month, Day, Year)		
		30. Name and add	dress of person	completed cause of	of death (Item	n 23a) (Type,	Print)	PAITILE	ore, w	WY AND) 2/22/		
	ate	31. Data filed (Mo		_	istray's Signa	iture	5 Loo	who will	or M	aklouin	ULL		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month **Physician** 6:00PN mer 12 260 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Arbutus 5720 Oakland Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 13 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months 13M 20 F Yrs. Maryland 80 Director 216-07-6123 Usual Rasidence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2X No Directo Maryland | Baltimore must be notifie Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21227 5720 Oakland Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Merial Hygiene. Important: If Item 27 is marked other in any Injury or other treatment of the page. 12. Was Decedent Ever in U,S. Armed Forces? 12∏Yas 2 □ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Nevar Married 2 X Married 1 Yes 2℃No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentery/Secondary (0-12) College (1-4or 5+) Shoe Store Manager 11 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Genevieve Sank Walter Edward Rose 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 5720 Oakland Road Arbutus, MD 21227 Alma E. Rose (Wife) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10 Burial 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) 12/30/99 Baltimore, MD Loudon Park Cemetery 21. Signatura of Funeral Service License Ambrose Funeral Home of Lansdowne W 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part1. Enter the disaasa, or complications that was the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only ona ceuse on each line. Approximata Interval Between Onset and Death **Physician** Immediete Causa (Final disaase or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner ettending physicien and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Dua to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy this certificate 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only ona) examinar? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending invastigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completaly filled in by the fun 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida

State

Registrar

edical

29a. Cartifier

(Check only one)

29b. Signature and title of certifia

MD 32. Registrar's Signature

who completed causa of death (Item 23a) (Type, Print)

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

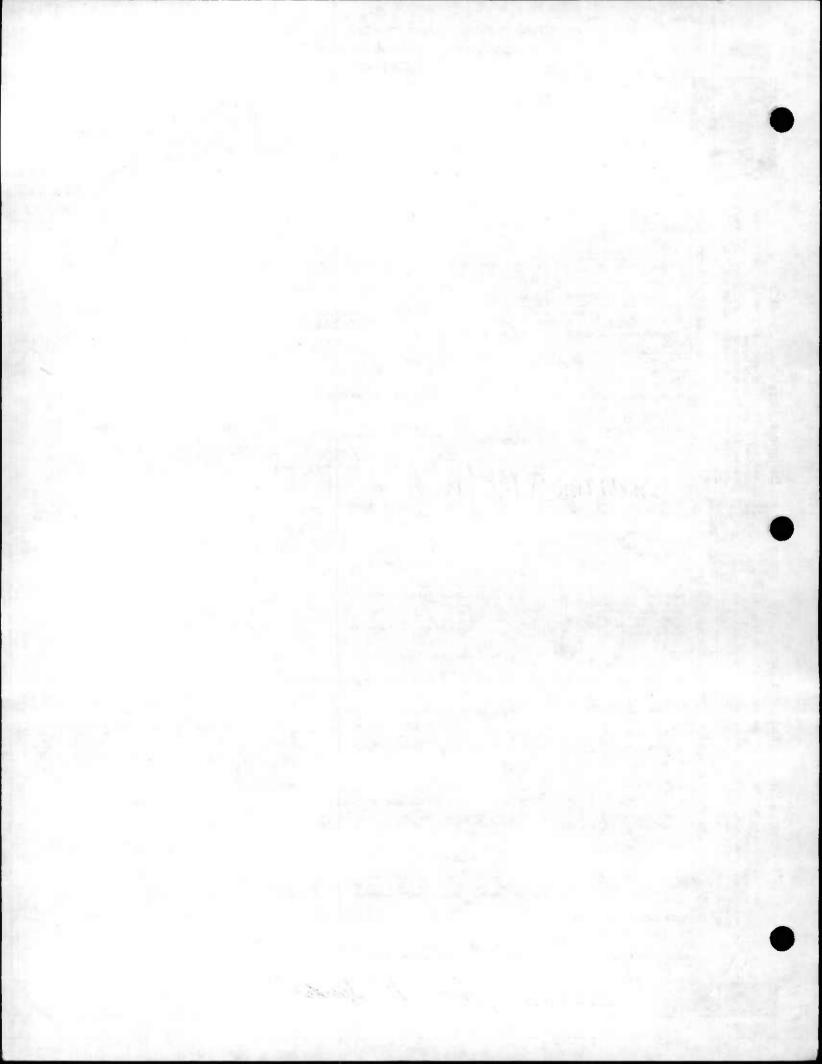
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

38662

Wilkens Ave Baltimore

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40747 Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Nancy DeCastro Ryttenberg 99 4:05 Pm Dec /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Dec. 15, 1917 Charlestown Care Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Yes 219-03-6782 Director New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limite "natural", or items 23a or 28a-f ahow roleal Examiner must be notified at 1 Yes 2X No Director Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 707 Maiden Choice Lane Apt. 8114 21228 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Never Merried 2 Married
3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give X Year or Dates: White Baltlmore, Maryland 21215-0020 *natural', or 1 ☐ Yes 2 🖾 No Specify: Specify: White p Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 ahould be flied within 7:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Madia once. 1 and 2 abould be flied within 1 death and Mental Hygiene. In 27 le marked other than *! Elementary/Secondary (0-12) College (1-4or 5+) 5.+ Social Worker Medical 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Charles Ryttenberg Anita Lazaron 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alice Gamse /cousin 2210 Kenoak Road Mt. Washington, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 【XCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. 12/30/99 Towson, MD 21. Signature of Funeral 22. Name and Address of Facility Stephen D. Coster Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Perff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feiture. List only one cause on each line. Approximate tntervat Between Onset end Deeth **Physician** /Medical tmmediete Cause (Final Ovarian months disease or condition resulting in death) Examiner Ryttenberg buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy 2 No 1 Yes 2016 1 ☐ Yes of Vital Attending Physician: 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) December 27, 1999 0 Andres Maiden Choice Lane, Catonsville, MD, 21228 Salazar 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State DEC 2 9 1999

DHMH 16 Rev 6/95

Registrar

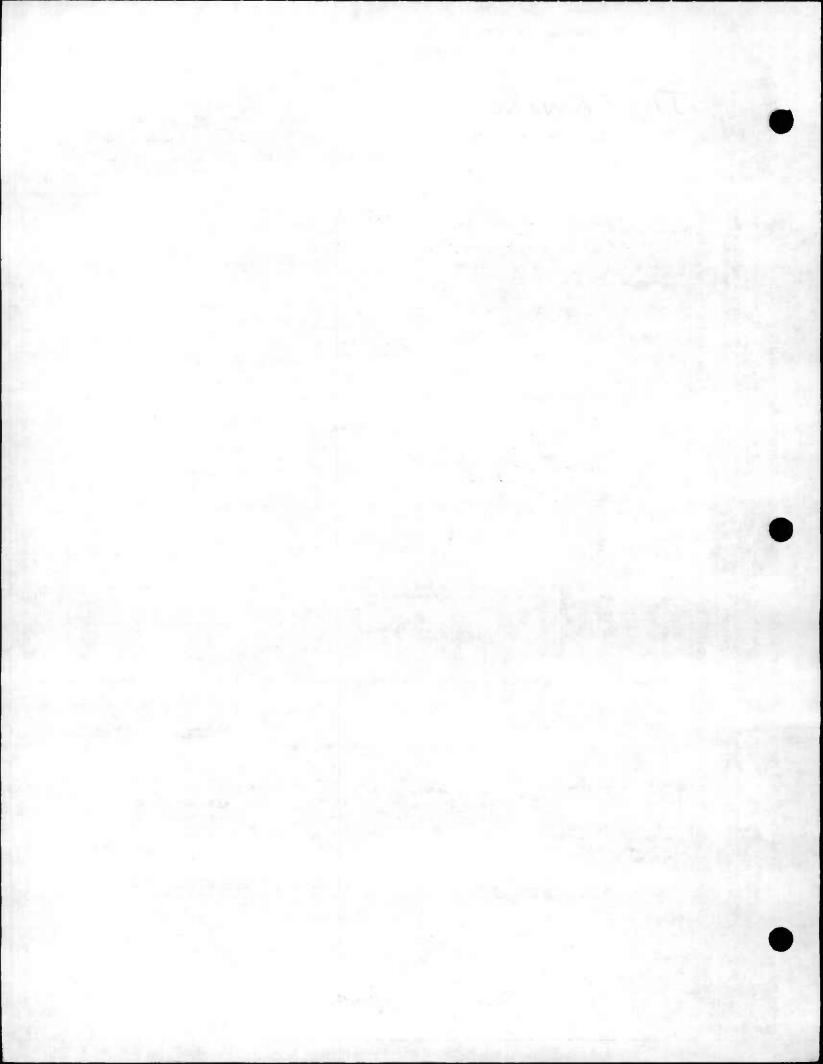
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Name

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death **Physician** 8:00 pm KANZINO December 22, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 1117 Castle Harbor Way, Unit 2D Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours XXM 2□ F Yrs. 82 8/29/17 Director 217.01.3535 MD Usuat Rasidanca of Decedant 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1117 Castle Harbor Way, Unit 2D 234 21060 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 12. Was 2 □ No If Yas, Giva Yaar or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) "naturel", or items 11. Marital Status 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 WUTT 1 Yes 2\ No Specify: Specify: WHITE à 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 FLORIST SELF EMPLOYED permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe eny Injury or other traumatic event, pages. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Peter J. Ranzino Florence V. Kemp 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informent's Neme/Reletionship (Type, Print) Florence V. Darby 1117 Castle Harbor Way, Unit 2D, Glen Burnie, MD 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata Entombment
3 Ramovat from Stata 1 ☐ Buriai 2 ☐ Cramation Cedar Hill Cemetery 12/28 4 Donation XX Othar (Specify) Baltimore, MD 21. Signature of Funeral Service Licen 22. Nama and Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 Kelly Gregory Fink 23a. Paul . Enter the dissusse or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hoar failure. List only one cause on each line. Approximata Intarvat Between Onset end Death **Physician** tmmediete Causa (Final disaasa or condition resulting in daath) /Medical olon Cacinomo 5 Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, taading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated evants resulting in death) Last ettanding physician and for use as the bunal-trar Due to (or as a consequence of): Box 68760 Dua to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No Division of Vital Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this cartificately filled in by the funeral director. 25. Was case rafarrad to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yas 2 No 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 Neturet 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 T Homicida 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

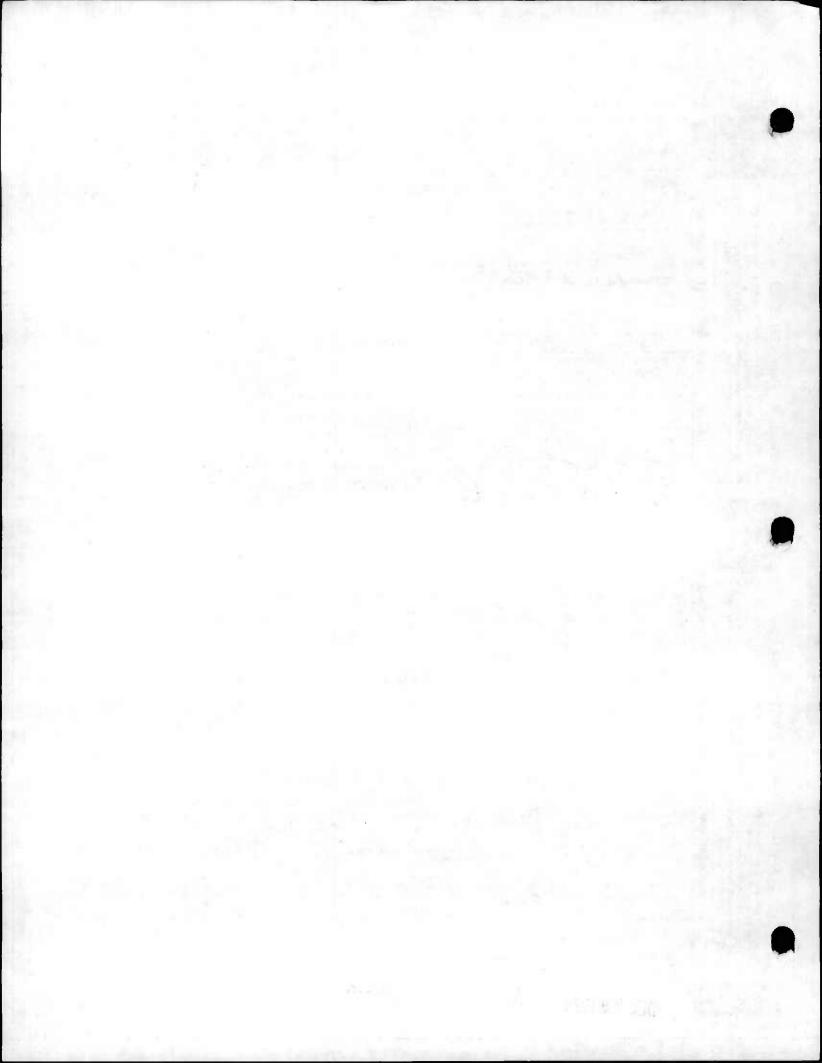
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier within 24 hou To the Fune completely fil ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signetura/ State DEC 2 9 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene o

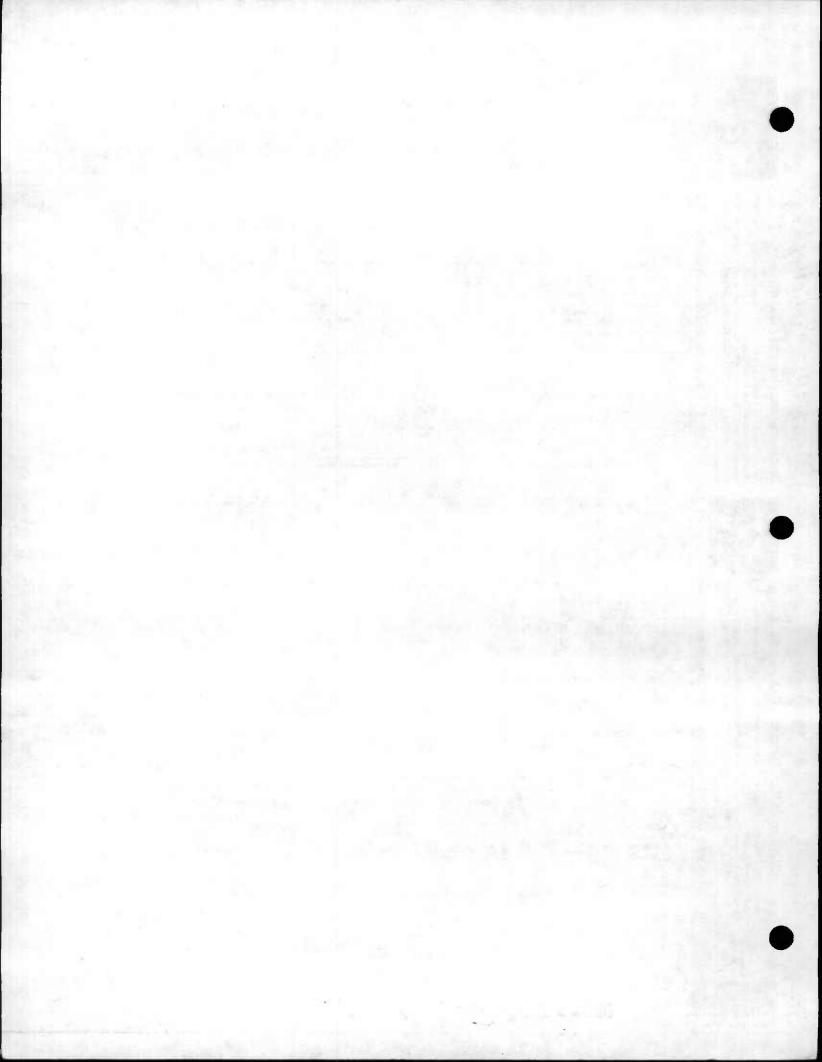
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** Isabelle a emper /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3961 Weaver's Court Ellicott City If Under 1 Year | If Under 24 Hrs. | 8. Defe of Birth (Month, Dey, Year) Howard Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Yrs. Director 78 820-07-9946 March 21, 1921 Tennessee Usuel Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Ellicott Clty 10e. Street and Number 10g. Citizen of Whet Country? ra 23a 21043 3961 Weaver's Court U.S.A. should be filed within 72 hours after death and Mental Hygiene. marked other than "naturel". or Itama 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give / Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Merried 1□ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker Unknown Unkn 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sabelle Be Pages 1 and 2 should be finent of Health end Mental I and: If Item 27 is marked of Jessie Collins Docia Mullins 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3961 Weaver's Court Ellicott City, Maryland 21043 Mr. Michael Ringley 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Depertment of F Important: If the eny Injury or off 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Crest Lawn Memorial Gardens 12/23/1999 Marriottsville, Maryland 22. Name end Address of Fecility 21. Signefure of Funerel Service Licensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximete Intervel Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical Liver Failure Examiner 6 Morth Physician/Medical Examiner patocella Attending Physician: The law requires that the death certificate be asscuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of P.O. Box 68760. thet initieted events resulting in death) Lest the Due to (or as e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be det Records, þ 24b. Were autopsy findings evaileble prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 28 No 1 ☐ Yes 2 No 1 Yes Division of Vital funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end fitle of certifie 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 900 Caton Associa 100 7 ichael Galla 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar DEC 2 9 1999

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth Dev Allyn. Month **Physician** RAFFERT 11-4797 December 27, 1999 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of De Examiner Columbia Howard County General Hospital Howard If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 KF Yrs. Director 030-18-1002 81 September 9, 1918 Massachusetts Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a 21044 6336 Cedar Lane USA Funeral filed within 72 hours after deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours siter of Department of Health and Mental hyglene. Important: if itam 27 is marked other than "natural", or herr any injury or other traumatic avant, the Medical Examples page. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker 9 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Wesley Wright Hazel Verne White 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1324 Chapelview Drive Odenton, Maryland 21113-2149 Mrs. Marcia Galbreath Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Merrigrove Immaculate Conception 12/31/99 Swanton, Ohio Cemetery 22. Name and Address of Fecility 21. Signature of Funerel Service Licenses Ansberg-West Funeral Home, Inc. 3000 Sylvania Ave. Toledo, Ohio 43613 M01204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical INFARCTION MYOCARDIAL Examiner Due to (or as a consequence of): Physician/Medical Examiner YPERTENSION The lew requires that the death certificate be axecuted for use as the burial-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dementia 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, à paga 2 should be 24b. Were eutopsy lindings evailable prior to completion of cause of deeth? Be Completed Renal Insufficiency 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificate To the Hospital or Attanding Physicien: Within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, lerm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29e. Cartifier (Check only one)

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year) DEC 2 9 1999

29b. Signature end title of certifier

32. Registrar's Signature

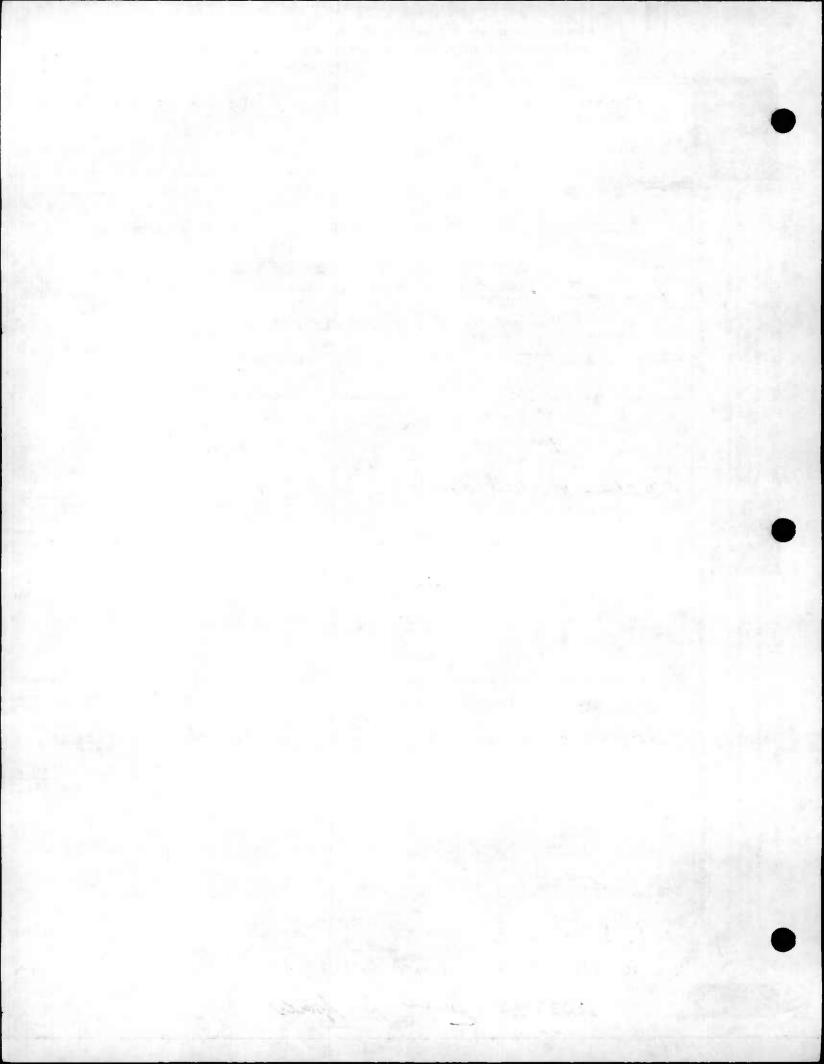
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIVE: \$100 - ELLICOTT CITY: MD. 21042

29c. License number

.30469

29d. Date signed (Month, Day, Year)

December 27, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

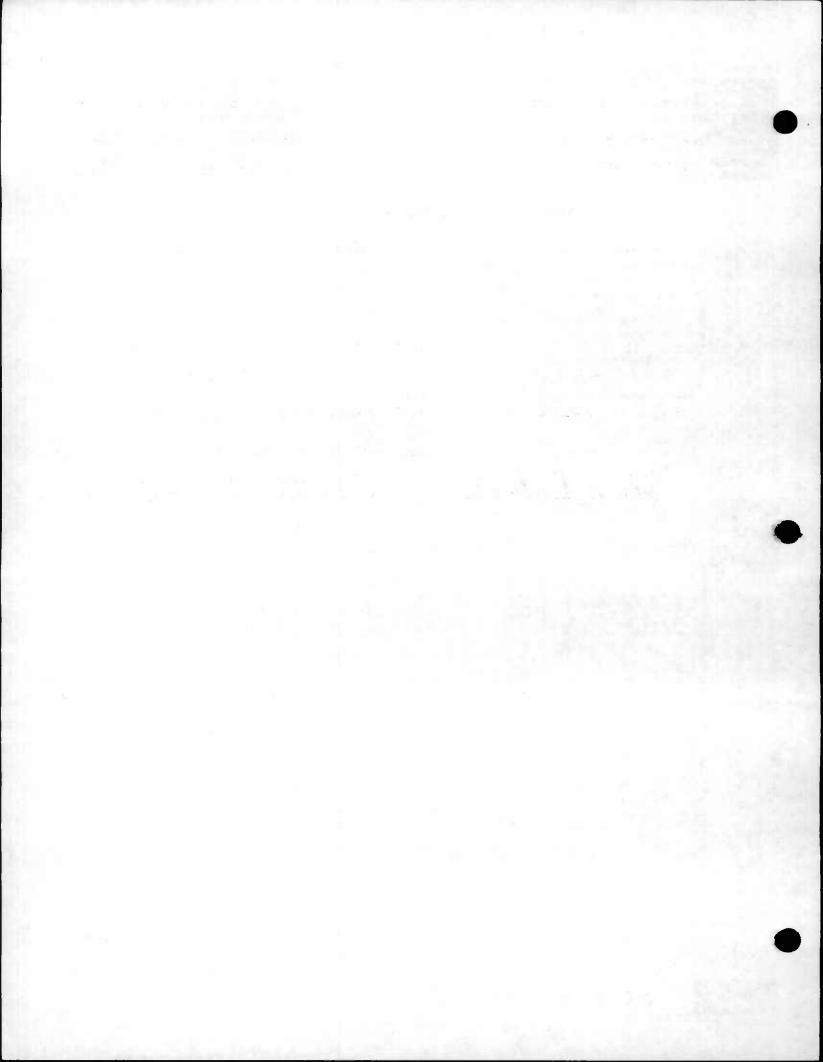
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 25, 1999 Month **Physician** Richard J. Rhinehart December 3:31 p.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 9 Whitethorn Way Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours to M 2□ F 215-32-4343 Director 64 May 11, 1935 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location show 10d. inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f sho other traumatic event, the Medical Examinan mast be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 X No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 9 Whitethorn Way 21220 U.S.A. Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status 14. Reca - American Indian, is 1 and 2 should be filed within 72 hours aftar of Haalth and Mental Hygiane. Itam 27 is marked other than "natural", or itan Bleck, White, etc. 1 Yes 27 If Yes, Give Year or Detes: 1 Never Married 2 Married 20 No 21215-0020 1 Yes 2 No Specify: þ Specify: 3℃Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 11 Floor Finisher Construction Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be permit. Pages 1 and 2 should be.
Department of Health and Mental h.
Important: if item 27 is merany Injury or other-Richard J. Rhinehart Mildred E. Barth 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mildred Keerans (mother) 1000 Franklin Avenue, Essex, Maryland 21221 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Greenmount Crematory 12/27/1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Lic 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

The disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting In death) Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest tha burial-trait Box 68760, attending physiclan Physician/Medicai Due to (or es e consequence of): ed by the a detached f Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0.0 signed by t 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Records, þ 24b. Were autopsy findings evelleble prior to page 2 should Completed 24a. Wes en eutopsy performed? been completion of cause of deeth? certificata 1□ Yes 2☑ No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 XNo 2 ☐ ER/Outpetient 3 ☐ DOA this funerai 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Aftar 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the or Attendation of the deat 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours a 24 hours a 29a. Certifier Medicai 1 🔀 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. completely (Check only one) 2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. To the I within 2 To the F 29b. Signeture end title of certifier 29d. Dete signed (Month, Dev., Yeer) 100/0032 aus 30. Neme end address of person who completed cause dideath (Item 23a) (Type, Print) Registrar's Signe State Registrar

HH

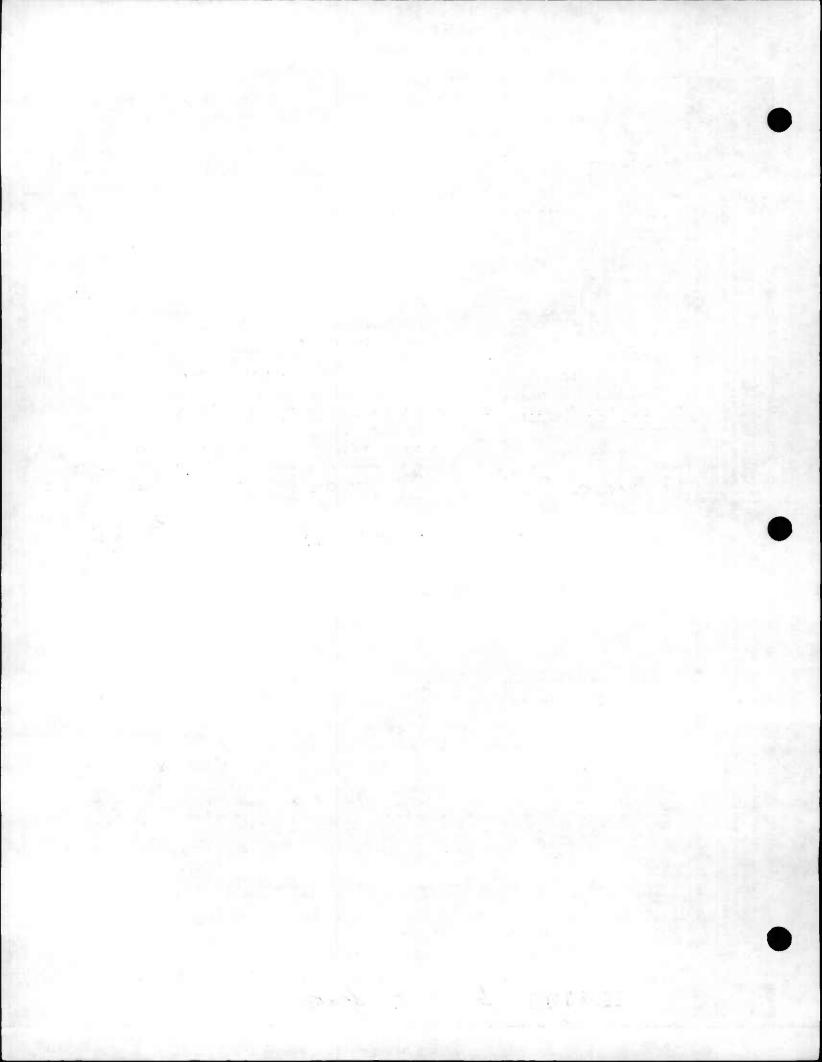
DHMH 16 Rev 6/95



Please Type or Print in Black indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Elizabeth Frances Rampello December 27, 1999 4b. City, Town, or Location of Death 4c. County of Death Dundalk Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 28, 1914 7. Aga (In yrs. last birthday) 1□M 2XXF Yrs. 85 Maryland 10b. County 10c. City, Town or Location Dundalk Baltimore Co. 10g. Citizen of What Country? 10f. Zip Code United States 21222

Physician 8:20 a.m. /Medical 4a Facility Name (If not institution, give street and number) Examiner Genesis Eldercare Heritage Center Baltimore Co. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 220-24-0840 Director Usual Residence of Decedent with the Maryland 10a. Stata 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Directo Maryland 10e. Street and Number 7232 German Hill Road Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ 1 M No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 6 yrs. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Be Scott Preston Madeline Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Elizabeth F. Karukas / Daughter Bel Air, Maryland 21015 703 McLean Court 20b. Place of Disposition (Name of cematery, crematory or othar place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State 12/29/99 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee Michael E. Canapp 22. Nama and Addrass of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** algerimere lensità /Medical Immediate Causa (Final disaasa or condition rasulting in daath) Examiner Examiner sician and burial-transit Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): the death certificate be execu physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death2 signed by d 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. g 24b. Wara eutopsy findings availabla prior to completion of causa of daath? Completed 24a. Was an autopsy parformed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case ratarred to medical axaminer? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 2 ER/Outpatient 3 DOA funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending invastigation al or Attending s after death. I Director: Aft of in by the fur 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral C completaly filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) V 703 S.CL INTOUST BALTMORE MD 21224 MD 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** December 23, 1999 7:46am Marie Rodgers A. /Medical 4c. County of Deeth 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner ARUNDEL AACOUNT HOSPITAL SEN BURNIE 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Hours Yrs. 85 217-01-8706 Director Sept. 15,1914 Maryland Usuel Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 23a 21222 United States 8 Northship Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify 3 ☑ Widowed 4 ☐ Divorced Yeer or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Store Clerk Retail Sales 5 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi Anne Kotowski John Kocur 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 21122 Carolyn Wright/Daughter 217 Carroll Road 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete ъ 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 Donetion 5 DOther (Specify) 12/29/1999 Dundalk, Maryland Holy Rosary Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Approximate tritervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical MYOCAND Examiner Due to (or es e consequença of) Physician/Medical Examiner FERIS SCIANOL The law requires that the death cartificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) P.O. Box 68760. attanding physician for usa as the bune Due to (or es e consequenca of) Pert It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ata has been signed by paga 2 should be datac 3 Probably 4 Unknown 1 Yes 2 40 Records, PV 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? Auntic Strussiz 1 Yes 2 No 1 ☐ Yes 2 No Chamic certificata Division of Vital 25. Wes case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Aftar 1 Natural 5 Pending investigation e Hoepital or Attending n 24 hours aftar death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end menner as stated. Medical complataly (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end menner steted. To the F within 2 29b. Signeture and title of or tifier 29c. License number 29d. Dete signed (Month, Dey, Year)

Registrar

State

31. Dete filed (Month, Day Year)

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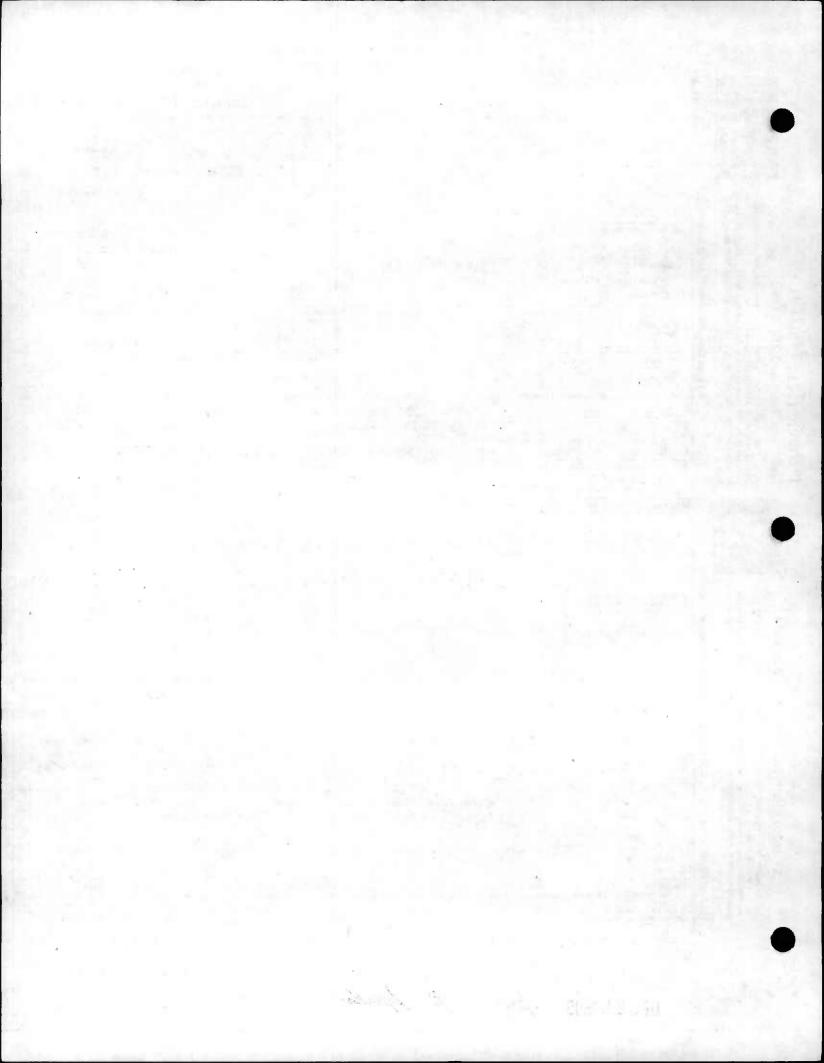
2112

Purdall

2/272

d eddress of person who completed cause of deeth (ttem 23a) (Type, Print)

32. Registrer's Signetyre



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month STEVENS QUINTON DECEMBER 24 1999 4e Facility Neme (Il not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death AL If Under 1 NA 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days XXM 2DF 219-66-5627 42 Yrs. 03-11-57 MD Usual Residence of Decedent 10a Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits NA 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 Robb Street 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 Mo If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Odd Jobs GED 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Andrew Stevens India Thomas 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) India 2611 Robb Street Baltimore, Maryland 21218 Powell 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete MD 20a. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Garrison Forest VA Cem. 12-29-99 Owings Mills, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or completations that excised the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in deeth) SEPSIS HOURS Due to (or as a consequence of): RETROVIRAL DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/Medical Examiner The law requires that the death certificate be executed bunal-tran physicien the buria Division of Vital Records, P.O. Box 68760. by Completed Hospital or Attending Physician: Be edical Certification: To this within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral of

Physician

/Medical

Examiner

Director

Funeral

à

Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours affer of Department of Heelth and Mentai Hyglene. Introdumit: if fem 27 is marked other than "natural, or free any Injury or other traumatic event, tre Medical and Budge.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0020

HEPATITIS	C INFECT	FION						
					24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Wes case referred to medical				26. Place of D	eath (Check only one)			
examiner?	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	M 2	Bc. Injury et Work? 1 Yes 2 No	28d. Describe how injury occurred			
3 Suicide 6 Could not b 4 Homicide determined					28f. Location (Street and Num City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowniner: On the basis of examination and menner steted.	owledge, death or ation end/or inves	ccurred estigation,	ot the time, date and plac in my opinion, death occ	ce, and due to the cause(s) and m curred at the time, date end plece,	anner as stated. and due to the cause(s)		

To the State

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) JAMES M SIZEMORE

29d. Date signed (Month, Day, Year) 29c. License number

RES -000

DECEMBER 24, 1999

21207

Registrar

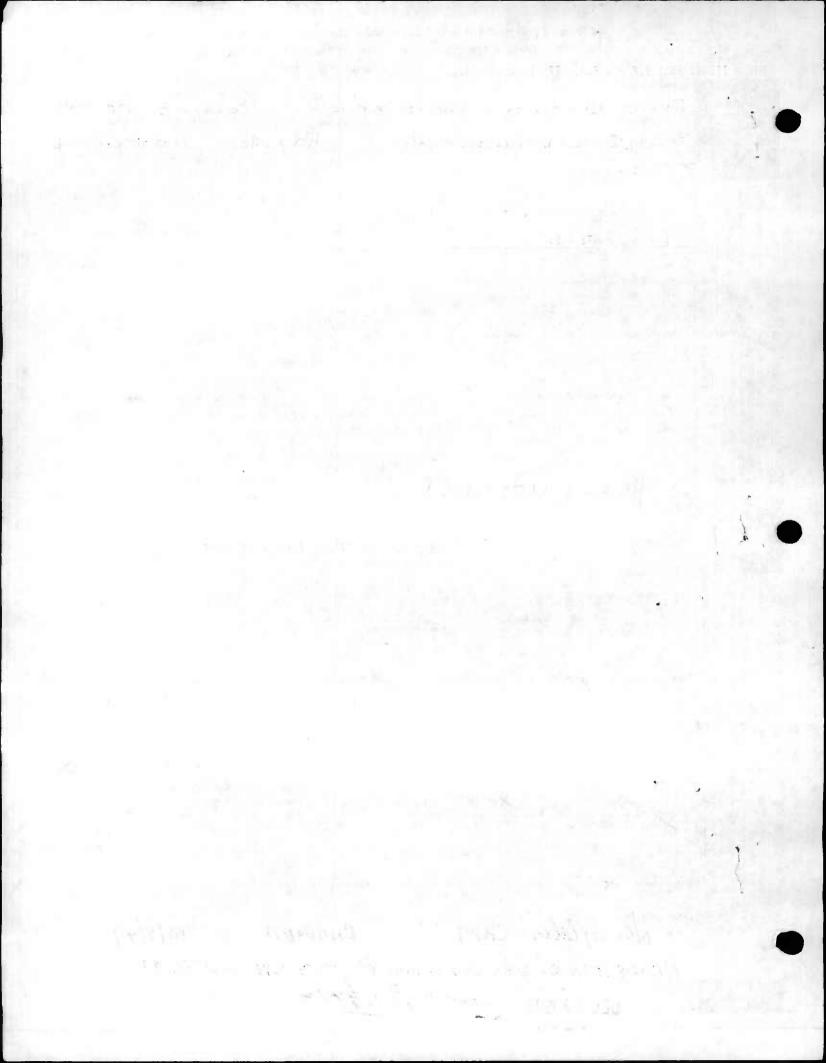
31. Dete filed (Month, Dey, Year) **DEC 29**

29b. Signeture end title of certifier

HOPKINS HOSPITAL TOWER 110 BALTIMORE, MD JOHNS mo 32. Régistrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

cian	1. Decedent's Nama (First, Middla,	3778 12-29-99 (Last)	AIV.		Death	2. Data of De		3. Time of Dec	eth	
ical	Patrick Chr	stopher	Rivere	1 Schoe	Ut	Month		1999 2145		
iner	4e. Facility Nama (If not institution,		11		4b. City, Town, or		13. 334.11			
	5. Social Sacurify Number N/A 219-44-6286 Usual Rasidence of Decedant	6. Sex 7. Ag	a (In yrs. last bii	thday) If Under 1 Year Months Days			th	9. Birthplace (Stata or Fo Country) Rockville,	oraign MD	
	10a. Stata 10b. County		10c. City, Tow	n or Location			THE STATE OF	10d. insida City Li	Imits	
ctor	DC none Washington, DC							1 Yas 2	□No	
Funeral Director	10a. Straat and Number 1300 BONAPARTE AV	/E.		10f. Zip Coda	21218		10g. Citizan of N	What Country?		
eral	2123 Observatory Place NW 11. Maritel Status 12. Was Dacadant Ever			-2000	•	Specify Vec or No	USA &	Canada e - Amaricen Indian.		
by	1 Navar Marriad 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	Armed Forces? If Yas, specify Cuben, Ma 1 □ Yas 2 ☑ No If Yas, Giva 1 □ Yas 2 □ No Sp					ck, Whita, atc.		
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To B	Pat Rivera-Spencer					garet S				
	19a. Informant's Name/Relationshi			. Mailing Addrass (Stree						
	Pat Rivera-Spe	ncer - Fath						ton, DC 2000	7	
	20a. Mathod of Disposition 1			Disposition (Nama of y, cramatory or other ple oyal Cemete		Data 12/11/99	Mont	City or Town, State real, Quebec Canada	,	
	21. Signature of Funaral Service Li	cansaa	- 0	22. Nama and Addr.		ral Serv	ice In			
	Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310									
	Part Enter the deeper, or comprications that ceused the death. Do not antar the mode of dying, such as cerdiac or raspiretory arrast, Approximate Intervel Batween Onset end Death									
	Immediate Cause (Finel	1.	3710-	6 " 0	h . c	2		Crisal end Daali	II)	
	disaasa or condition rasulting in death)	- By51	M319							
iner	Dua to (or as a consaquanca of):									
Examiner	Sequentially list conditions,	Dua to (or as a consequance of):								
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Medical	that initiated events resulting in daath) Last	d	Dua to (or as e o	onsequance of):						
Physician/	Part II. Other significant conditions	23b. Did	23b. Did tobacco usa contributa to the cause of death?							
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Completed by							24a. Was en eutopsy performed? 24b. Were a availat comple			
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	25. Was casa raterrad to medical				26 Place of Dec	1 Chack only	/ '	1 ☐ Yes 2 No		
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To Be	1 ☐ Yas 2 No	1 Inpatie		28b. Tima of lnjury Work?			oma 5 ☐ Rasidanca 6 ☐ Othar (Spacify) 28d. Describe how injury occurred			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Deeth Month **Physician** Adam V. Scherer 27, 1999 10:15pm Dec. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Nursing Home Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 18, 1 6 Sex 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Months Days ØM 2□F Yrs. 96 1903 Director 092-01-9329 PA Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28s-f shorts the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11 Colgate Court 21228 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Wes Decedenl of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Never Married 2 Merried White 1□ Yes 2□ No Specify: Specify: p 3⊠ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Furniture permit. Peges 1 end 2 should be file Department of Health end Mentei Hy Important: if fiem 27 ie marked othe eny Injury or other treumatic event, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Katherine Wagner Adam Scherer 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Colgate Court Catonsville, MD. Rev. Arthur Scherer (Son) 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 12 - 301. Burial 2 ☐ Cremetion 3 ☑ Removel Irom State Mansion Memorial Park Ellenton, Florida 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name end Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD. 21227 23a. Part 1. Enler the disease, or complications shock, or heart teilure. List only one cause Approximete Intervel Between Onset end Death Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical 6 mos Cance Examiner Due to for as a consettuence off: Physician/Medical Examiner anding physicien and use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown à 24b. Were autopsy lindings evailable prior to completion of cause ot deeth? Be Completed 24e. Was an autopsy 1 ☐ Yes 2 3 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Placa of Deeth (Check only one) Other:

A™Nursing Home 5 □ Residence 6 □ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatienl 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending investigation

The lew requires that the death certificate be executed P.O. Box 68760. Records,

the Meryland

a filed within 72 hours after death if Hygiene. other than "natural", or items 23

Baitimore, Maryiand 21215-0020

Division of Vital or Attending Physicien: To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: After completely filled in by the fun

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this certificate

After

State Registrar

DHMH 16 Rev 6/95

MD 11305 31. Date filed (Month, Day, Year) DEC 2 9 1999

6 Could not be determined

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

30. Name and address of person V

Park 7770 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify)

Hoights Ave

1 ☐ Yes 2 ☐ No

1737573

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29c. License number

Battime MD

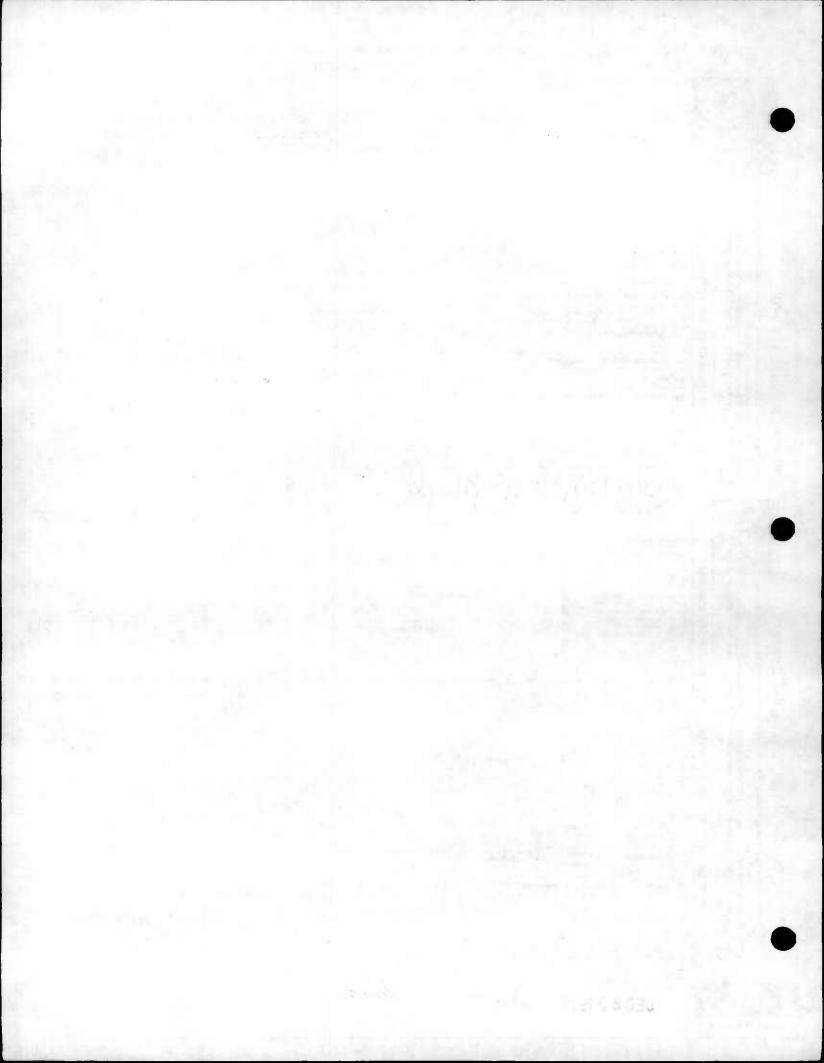
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28l. Location (Street end Number or Rurel Route Number, City or Town, State)

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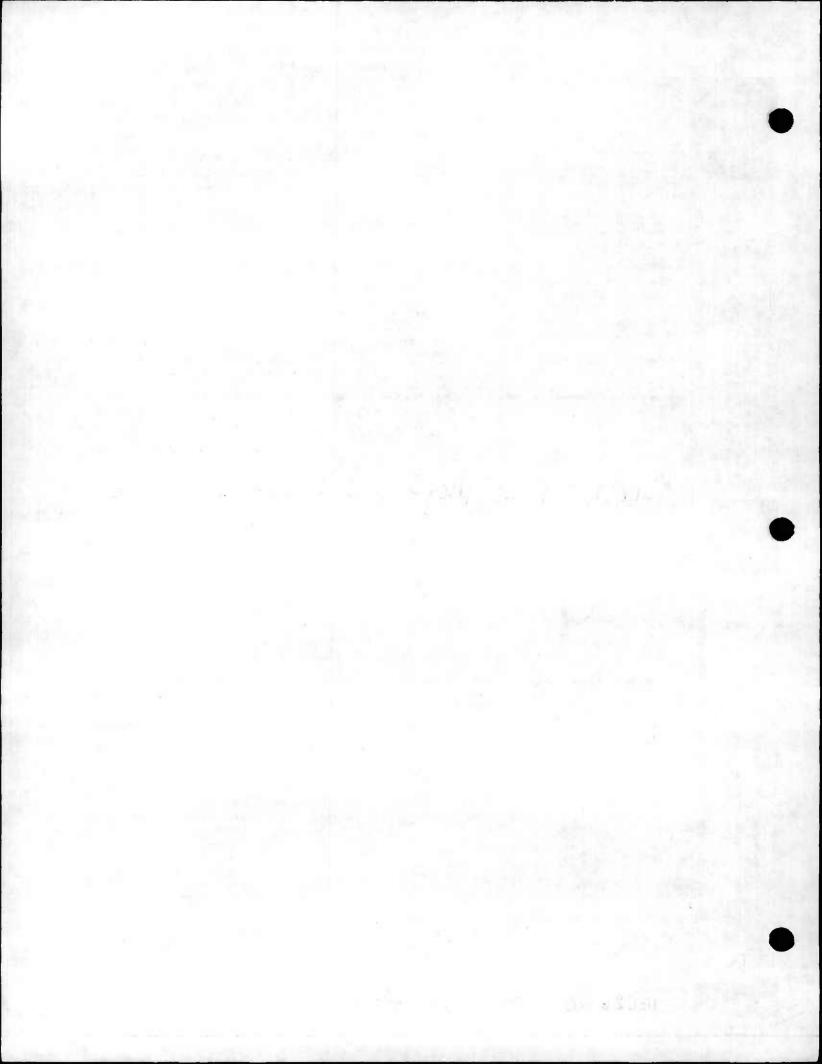
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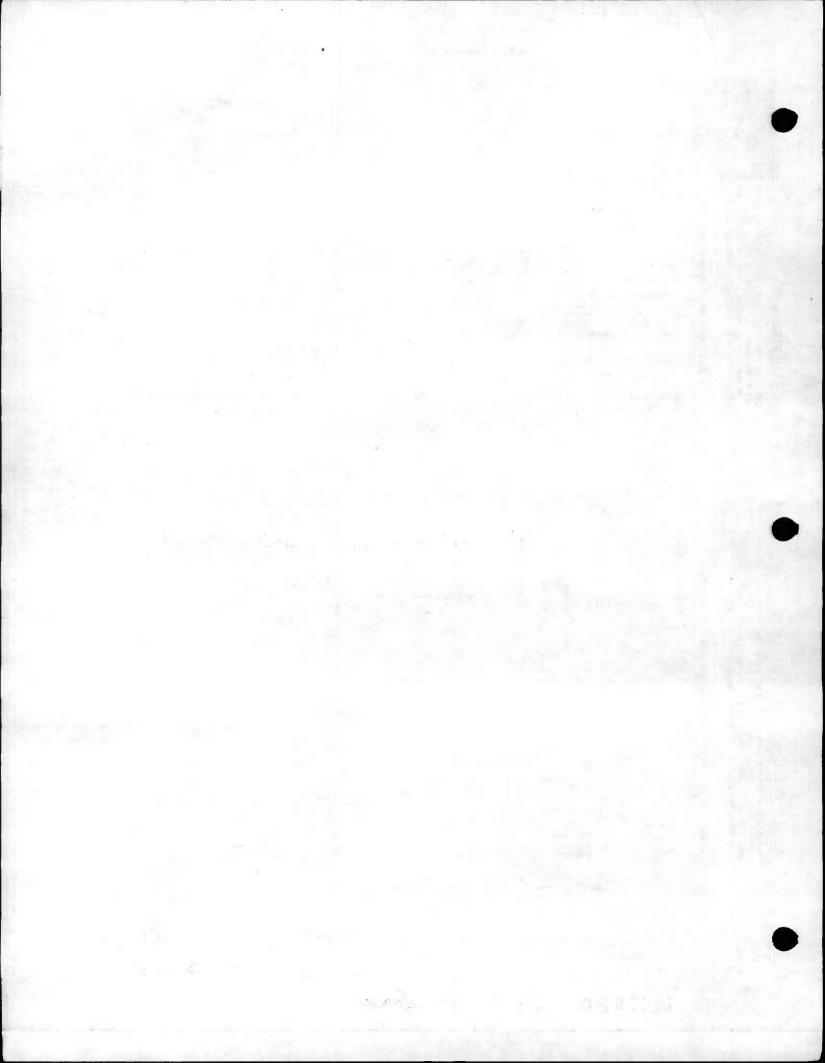
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070	72 hours after death with the Maryland natural; or items 23s or 28s-f show site Examiner must be notified at steed by Funeral Director		arried 2 Married 4 Divorced	12. Was Decedent Armed Forces 1 XYas 2 1 If Yes, Give Yaar or Datas:	No 26-45	13. Was Decedent of It Yas, specify Cu		ecity Yes or No Rican, atc.)	Black,	-Amarican Indiar White, etc. White	1,
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	icate be executed physician and s the burial-transit adical Examir	Sequantially list if any, laading to	conditions, immediate		Due to (or as a	consequence of):					
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<u>a</u>	certificate he rector, page							10	Yes 2 No	1 🗆 Yes	2 🔼 No
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29a. Certifier (Check only one)	Check only 2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							se(s)	
	within To the comp	29b. Signature ar	nd title of certifier	7	2 (29c. Licer	nse number		29d. Data signad	(Month, Day, Yea	ir)
		1/21	egared	14.15	eller	D2	9505		12-27	-99	
	1	30. Name and ad	dress of person who	completed cause of c	leath (ttem 23a) (Type, Print)					
		GREGO	RIO M. B	BELLOSO	MD:5	Sporks	BERRY DA	:: SAL	ISBURY.	MD 21	801
	State	31. Date filed (Mo	onth, Day, Year)	32. Registr	ar's Signature	Aprila)					
,	Registrar	UEC	2 9 1999	Link	~	Maria					

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		State of Marylai	Certific				Reg. No.	40/59	
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/Medical	Eugene H. Storm					ECEMBE	R 23, 19	999 Ø8:36 PM	
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Funeral Director	220 21 0000	7. Age (In yrs	. last birthday) If Ui Mon	ths Days	If Under 24 Hrs Hours Min.	(Month, D.	th ay, Year) 16, 1928	9. Birthplaca (Stata or Foreign Country) Maryland	
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or 28e-f e	10e. Street and Number	10f	. Zip Code			10g. Citizen of Wh	nat Country?		
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frer death v	11. Marital Status	12. Was Decedent Evar in U			lispanic Origin? (S en, Mexican, Puer	Specify Yas or N		- Amarican Indian,	
of, or he by Fur	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? If Yas, specify 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Datas:			en, Mexican, Puer Specify:	to Rican, atc.)	Black, Whita, etc. Specify: White		
neturel',	15. Decedent's Edu	cetion	16a. Decedent's Usual Oc		pation	-	16b. Kind of Bus		
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the and Mental Hy Ta marked othe treumatic event,	Henry Storm			Emma 2	Anton				
and Menta la marked reumatic ev	19a. Informant's Name/Ralationship (T)	me Print)	19h Mailing Add	19b. Mailing Address (Street and Number or Rural Ro			er City or Town S	Nata Zin Code)	
475	Donald Storm, Son			-				21061	
if of Health	20a. Method ol Disposition	20h Blace of Disposition (Name o			and Date Total China Tarra City				
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certificate has rector, page 2 Be Comp						10	Yas 20No	1□Yes 2□No	
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To the Hospital or Attending Physics 24 hours after death. To the Funeral Director After this completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be detarmined	9 19a Place of Injury. At home few stant Leaves office. 28t Leaving (Street and Alumber or Pural Pouts Number.						r or Rural Routa Number,	
To the Hospital within 24 hours a To the Funeral completely filled Medical Ce	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	ner: On the best of my knowner: On the besis of examination and manner stated.	owledge, death occur ation and/or investiga	red at tha tir tion, in my c	me, data and place opinion, death occu	e, and due to the urred at the time,	causa(s) and man data and placa, ar	ner as stated. nd due to tha causa(s)	
within 2 To the comple	29b. Signature and titla of certifier			29c. Licens	se number		29d. Data signed	(Month, Day, Year)	
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	MI Tulin	some has	4-111	NI	(11)7		100/2	1111	
5	30. Nama and eddress of person who co	empleted cause of death (Item		20,	reur	na.	21001		
State Registrar	31. Data filed (Month, Day, Year) DEC 2 9 1999	32. Registrar's Sign	Acre &	61					



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State of Maryland / Department of Health and Mental Hygiene 40760 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** December 25 1999 12.25 AM James Emory Stewart /Medical 4a. Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** Future Care Sandtown Winchester Nursing Home Baltimore If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** ₩ 2 D F Months 92 217-01-6632 Director 09/20/1907 Virginia Usuel Rasidanca of Dacedent the Maryland 10e. State 10b. County 10c. City. Town or Locetion 10d. Insida City Limits show ral', or Items 23a or 28a-f show Examiner must be notified at 1 ¥ Yas 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 N. Pulaski Street 21217 Funeral U.S.A. death 12. Wes Dacedant Evar In U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, efc. filed within 72 hours after 1 ☐ Yes 2 No If Yas, Giva Yeer or Datas: 1X Navar Married 2 ☐ Marriad natural', or Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced nd Mental Hygiene. merked other than "naturimetic event, the Medical Completed 15. Dacedant's Education (Spacify only highest greda complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Insurance Agent Mutual Insurance 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Be d 2 should be fi th and Mental H permit. Peges 1 and 2 should by Depertment of Heelth and Menta Important: If Item 27 Is merked any Injury or other traumatic ev Alfred Stewart Kate Maith 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Coda) Peges 1 and 2 ment of Heelth a ant: If item 27 is Lureen Foote / Niece 3011 Spaulding Ave., Baltimore, Maryland 21215 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - Cify or Town, Stata 1 Burial 2 Cramation 3 Ramovel from Stata 4 Donation 5 Othar (Specify) Lively Hope Church Ceme. 12/30/99 Callao, Virginia 22. Name and Addrass of Facility Derrick C. Jones Funeral Home 21. Signatura of Funaral Sarvigna 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications and bused the deeth. Do not anter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on such line. Approximeta Intarval Between Onsat and Death **Physician** Immadiata Cause (Final disease or condition resulting in deeth) /Medical MYOCARDIAL INFARCTION MINUTES Examiner Dua to (or as a consequenca of): Examiner CARDIOVASCULAR DUSBASG YEARS ATHEROSCLEROTIC and bunal-tran Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury Due to (or as e consaquance of): P.O. Box 68760. certificete be Physician/Medical the that initieted avants Dua to (or as a consequence of): rasulting in death) Last use as t 5 Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 20 No 1 Yes 3 Probably 4 Unknown signed b Records, þ 24b. Wara autopsy findings aveileble prior to Completed 24a. Was an autopsy Deen complation of causa of deeth? certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was case refarred to medical 26. Place of Death (Chack only ona) axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatient 2 ☐ ER/Oufpetient 3 ☐ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After Attending Naturel 5 Panding investigation Injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide in by t 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Placa of injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 D Homicida Cartifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) end mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the fime, deta end place, and due to the cause(s) and mannar stated. edicai 29a. Cartifia pletely 29b. Signature and titla of cartifiar 29c. Licansa number 29d. Data signad (Month, Day, Yeer) DECEMBER 29th 1999 D42510 asanthalcumas. 30. Nama and eddress of person who completed cause of death (Itam 23a) (Type, Print) BALTIMORE M'VASANTHAKUMAN, 827. LINDEN AVEINE, MD21201

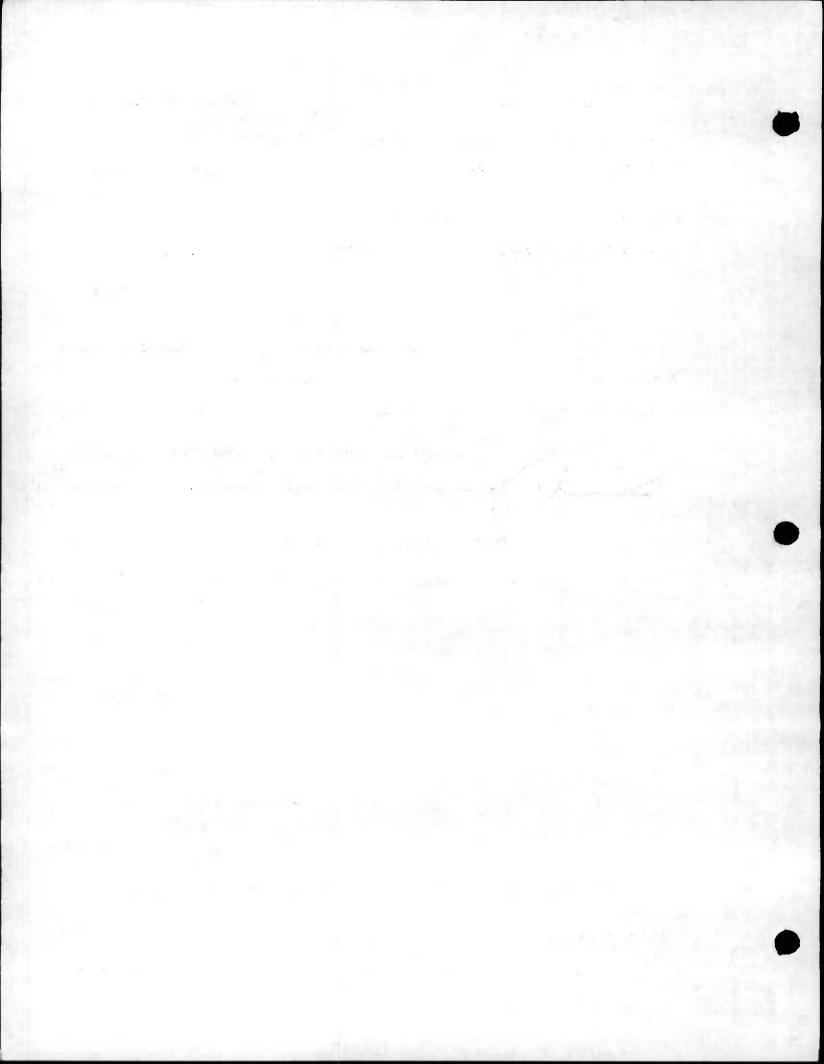
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Registrar

31. Data filed (Month, Day, Year)

DEC 2 9 1999

32. Registrare Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 8:05 PM Hazel E. Seibert 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Union Memorial Hospital N/A Baltimore If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Yrs. 74 220-12-4776 12-27-1925 Baltimore, MD Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits X Yes 2 □ No Maryland n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 1229 Union Avenue 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Stetus 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sherman Brooks Daisy Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1229 Union Avenue Baltimore, MD 21211
tion (Name of Date 20c. Location - City or Town, State Mr. Robert R. Seibert, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X) Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Lake View Memorial Pk 12/31/99 Eldersburg, Maryland of Funeral Se Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211.

23a Part Enter the Issuese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death Preumonia Immediate Cause (Final disease or condition resulting in death) ago Five years Due to (or as a consequenca of): cerebrovasular accident 290 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Diabetes NelliNS 24b. Were eutopsy lindings evailable prior to completion of cause of deeth? 24e. Wes an autopsy performed? Poor nutritional State 1 ☐ Yes 20 No 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

Hazel Seibert

Examiner Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

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Examiner

Physician/Medical

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Certification:

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Funeral

Director

Item 27 is marked other than "natural", or items 23s or 25s-4 show other treumstic event, the Medical Examinar must be notified at

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Physician

/Medical

physician and s the burial-transit

88 esn 0

signed by the a

page 2

certificate

After this

filled in by

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23.

Baltimore, Maryland 21215-0020

the Meryland

Attending Physician: hours after death. ò Hospitai 24 hours a

completely To the I within 2

Registrar

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Richard Dressler, MD

(Check only one)

29a. Certifier

29b. Signature and title of certifier

Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piace, and due to the ceuse(s) and manner steted. 29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

December 28, 1999

29 Sorth Paca Street, Bathmar, Mayland, 21201

31. Date filed (Month, Day, Year)

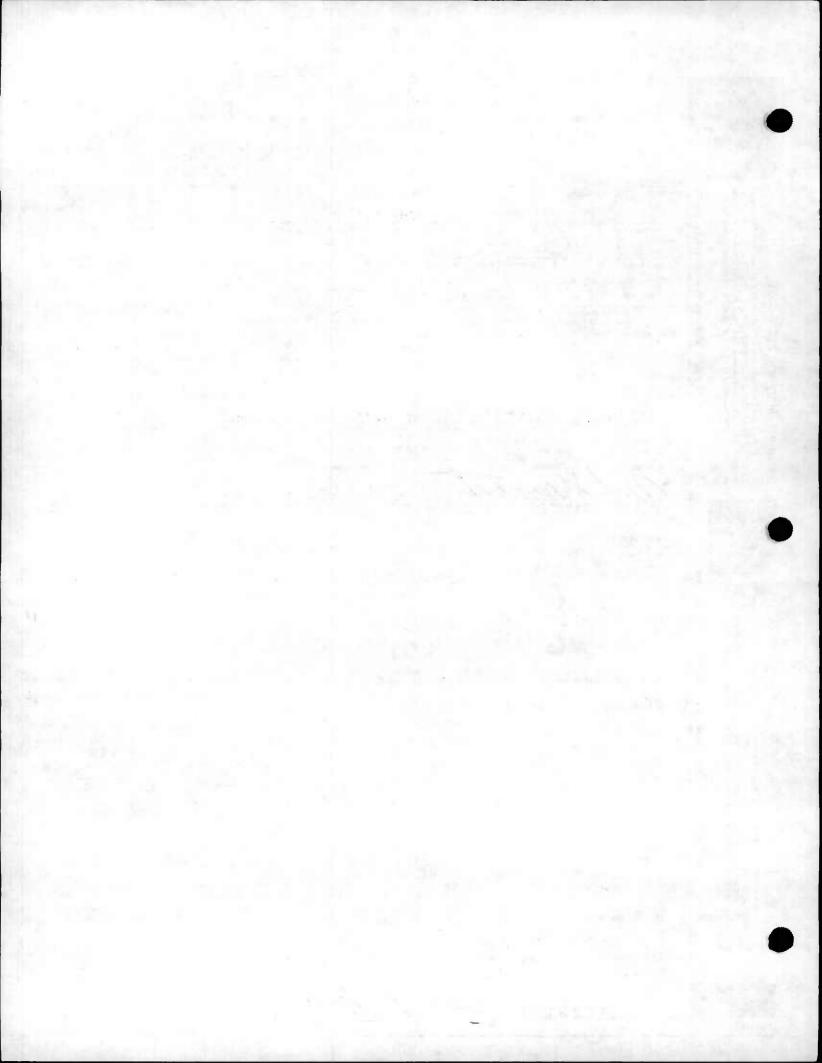
DEC 2 9 1999

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Dhysisian	1. Decedent's Name (First, Middle,					2. Dete of De Month	Dete of Death 3. Time of Dea			
Physician Medical		Jack L. Sp	icer,	Sr.		Decemb				
Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
	Greater Baltimo	re Medical Cen	ter		Towson			altimore		
Funeral Director	212-22-1915	. Sex 1XXXX 2□ F 73	s. last birthdi Yrs	Months Days	If Under 24 Hi Hours Mi		ay, Year)	9. Birthplace (State or Foreig Country) 26 Baltimore,		
pue *	Usuel Residence of Decedent 10e. Stete 10b. County	10c. C	City, Town or	Location				10d. inside City Limits		
with the Maryl or 28a-f sho		altimore	Lut	herville				1□Yes 2√		
after death with the Marylar or items 23a or 28a-f show miner must be notified at if Funeral Director	13 Nightingale	Ave. Apt. A9		10f. Zip Code 21093		U.S.A.				
F 7.8 0	11. Maritel Status 1 Never Merried 70 Married 3 Widowed 4 Divorced	12. Wes Decedant Ever in Armed Forces? 12. Wes Decedant Ever in Armed Forces? 13. Wes 2□ No 51. If Yes, Give Yeer or Detes: 43.	-52	3. Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2XXX6	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No orto Rican, etc.)		e-Americen Indien, k, White, etc. White		
ed within 72 hours ygiene. her then "netural", rt, tre Medical Exi Completed by	15. Decedent's (Specify only highest)	Education prede completed)	16a. De	cedent's Usuel Occupive kind of work done	ation during most of w	orkina	16b. Kind of Bu	usiness/Industry		
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0 0 0	19e. Informant's Neme/Reletionship		19b. M	eiling Address (Street	end Number or I	Rural Route Numb	er, City or Town,	Stete, Zip Code) 21093		
s 1 and 2 f Health Item 27 i	Mary M. Spice		13	Nightingal sposition (Neme of	le Ave,	Apt. A9	Luther	ville MD City or Town, Stete		
or of	20e. Method of Disposition XX Kuriel 2 □ Cremetion 3	20c. Location -	City or Town, Stete							
Pa Int:	4 Donelion 5 Dother (Specify) Evergreen Memorial 12/31/99 Finksburg, MD									
permit. Pa Departman Important: any injury once.	21. Signature of Funeral Service Lic	1 Home,	ome, Inc.							
	Burgee-Henss-Seita Funeral Home, Inc. 3631 Falls Rd. Balto, MD 21211 23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interest, or heart failure. List only one cause on each line.									
Physician	Shock, of right failule. List on	ly one cause on each line.				Approximete intervel Between Onset and Death				
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axecuted n and iel-transit Examiner	b. Million Condition and ge									
axeon in an in an in all-tr	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): Cause (Disease or Injury that initiated events Due to (or es e consequence of):									
The law requires that the death cardificata be assected that has been signed by the attanding physician and page 2 should be datached for use as the burial-transit completed by Physician/Medical Examir	resulting in death) Lest									
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the cy the ache	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Rheumature cuttlents						23b. Did tobacco use contribute to the cau			
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The law requires that the de sale has been signed by the a page 2 should be datached Completed by Physic							an eutopsy ormed?	24b. Were autopsy findings evailable prior to completion of cause of death?		
a has							Van OF	1000		
	OF Was once referred to madical						Yes 2 10	1 ☐ Yes 2 ☐ No		
Physicien: this certific ral director, TO Be	25. Was case referred to medicel examiner?	Hospitel:		ion all DOA Oth	er-	eeth (Check only				
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ath. r: Attains a fune	1 ⊟Neturel 5 ☐ Pending investigat		Injur	y Wo	k? Yes 2□No		28d. Describe how injury occurred			
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To the Hospital or Atte within 24 hours after da To the Funeral Directo complataly filled in by the Medical Certific		Physician: To the best of my kraminer: On the basis of examinend manner stated.								
withir To th comp	29b. Signeture and title of certifier			29c. Licens			29d. Date signer	d (Month, Day, Year)		
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1011	30. Nema and address of person who	o completed cause of deeth (Ite	23a) (Typ	w, cou)	spni	WG LA	Borge	MOUNO		
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrer's Sign	netura	5 Spar	KN					
ricgistial	DEC 2.9	1999		- / /						



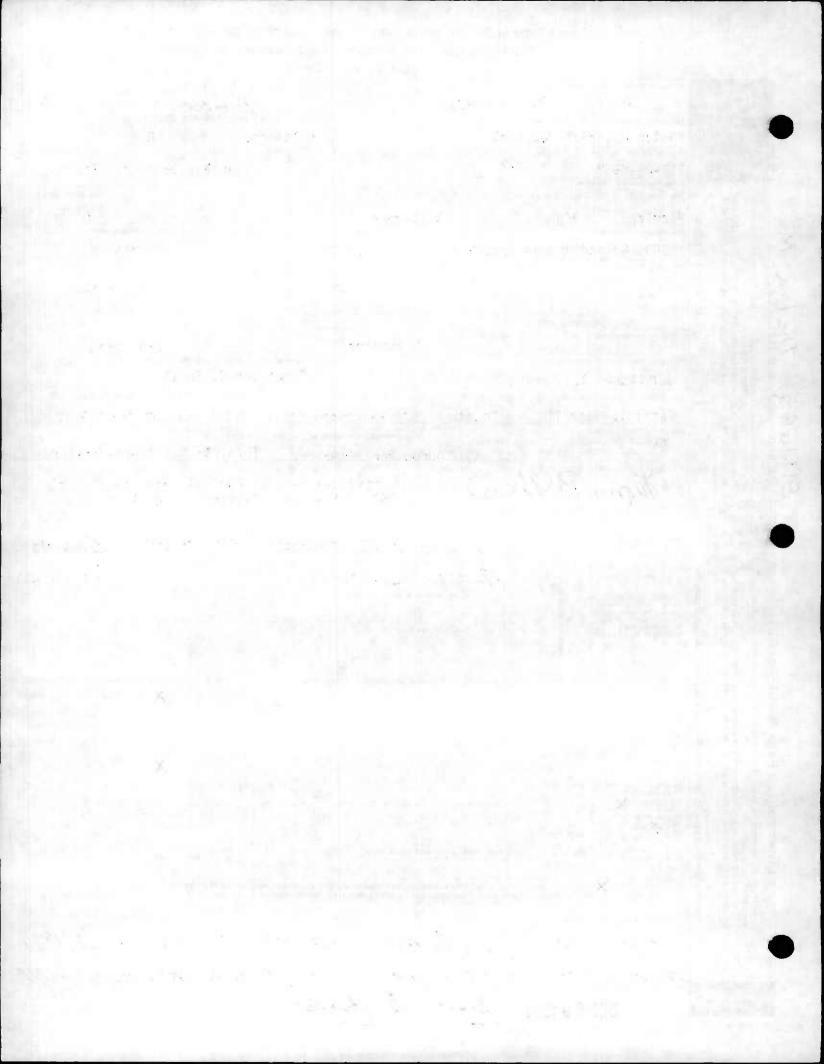
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Month Physician Thelma Spriggs Ecember /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 8. Data of Birth (Month, Day, Year) If Undar 1 Year If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours Months Yrs. 217-09-5958 87 March 6,1912 **Director** Maryland Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits X Yas 2□No Directo 288-4 Maryland N/A Baltimore 10f. Zip Coda 10g. Citizan of What Country? 10e Street end Number the Medical Examiner must be 3838 Roland Avenue Apt.1305 21211 USA Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 X X Yo If Yas, Giva Year or Detes: 1XX Navar Married 2 ☐ Married 1 ☐ Yas 2XXNo Specify: White Specify: P 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Buainass/Industry nd Mental Hygiana. marked other than Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own_Home 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fethar's Nama (First, Middle, Last) Be Catherine V. Engel William A. 10 Spriggs 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patricia Gosnell Cousin Stillwater, OK 74075-8239
Date | 20c. Location - City or Town, State 616 Wedgewood Drive 20b. Place of Disposition (Name of cematary, cramatory or other place) 20e. Method of Disposition XX Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 12/31/99 Baltimore, Maryland 4 □ Donathon 5 □ Othar (Spacify) Loudon Park Cemetery 21. Signatu Funaral Sarvice Licensas 22. Nama and Addrass of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a Part Levar the disease, or complications that ceusad the death. Do not after the mode of dying, such as cordiac disappration are shock, a heart failure. List only one ceusa on each line. Approximate tntarvat Between Onsat end Daath **Physician** FART FAILURE Immediate Causa (Final disaasa or condition rasulting in daath) /Medical **Examiner** Examiner 10 YEARS be executed Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disaasa or injury that Initiated avants rasulting in death) Last Due to (or as a consequence of) and burial-trar physician P.O. Box 68760 Physician/Medicai the Dua to (or as a consequance of) 98 attending p USB 23b. Did tobecco use contributa to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. detached 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 3 signed to by 24b. Wara eutopsy findings avaitable prior to completion of cause of death? Completed 24e. Wes an autopsy hes pege 2 1 ☐ Yas 2 ☐ No certificate 1 Yas Division of Vital director 25. Was cesa rafarred to medical Be 26. Plece of Death (Chack only ona) axaminar? Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred 1 Natural 5 Panding Invastigation efter deeth. Director: Aft 1 Yes 2 No 2 ☐ Accidant 6 Could not be datermined 3 Suicida 28f. Locetion (Streat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida ō 24 hours e Funeral I Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceusa(s) and mannar stated. 29a. Cartifiar Medical completely (Check only one) To the Vithin 2 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifian 29c. Licansa number aumond. Name and address of parson who complated causa of death (Itam 23a) (Type, Print) EAST UnivERSity Parkury, Baltimore, MD 21218 MD KEWIS

Registrar DHMH 16 Rev 6/95

31. Data filad (Month, Day, Year)

DEC 2 9 1999

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#20a PER F.H. G778 12-29-99 J.A Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth DECEMBER 37 1999 LEATRICE CHITOSE SHUTTLEWOOD 2:30 PM 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 6026 OLD HARFORD ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days 1 M 2 BF 575-20-3494 87 OCTOBER 30, 1912 HAWAII Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits BALTIMORE 1 X Yes 2 No MARYLAND N/A 10e Street and Number 10f Zin Code 10g Citizen of What Country? UNITED STATES OF AMERICA 6026 OLD HARFORD ROAD 21214 14. Rece - American Indien Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2NO Specify: JAPANESE Specity: ASIAN 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNION SUPPLY SEAMSTRESS 8TH GRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Sumi Sugiyama JIEMON KURASHIGE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ROBERT SHUTTLEWOOD 6026 OLD HARFORD ROAD/BALTIMORE, MARYLAND 21214 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Barial 2 ☐ Cremetion 3 Removel from Stete PUNCH BOWL NATIONAL CENETERY 12-36-99 HONOLULU, HAWAII 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee 6009 HARFORD ROAD ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD. 21214 Lonald R. Watson, 1. # moo612 23a. Part1. Enter the disease, or complicatives that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Mysicardial Inferction Immediate Cause (Final 2-4 hours disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 desidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of tnjury (Month, Dey Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident

Examiner The law requires that the deeth certificeta be executed ettanding physician and for usa as the bunel-tren Division of Vital Records, P.O. Box 68760 signed by the bluods page 2 After this certificate funerel director, pag or Attending Physician: death. Director: / 24 hours eftar Funeral Dire lataly filled in b Hospital

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Physician

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r than "natural", or items 23s or 28s-f show

permit. Pages 1 end 2 should be filed within 72 hours efter Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or ite any find yor other traumatic event, the Manical Earning any findury or other traumatic event, the Manical Earning.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

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Physiclan/Medical þ Completed Be P Certification:

25. Wes case referred to medicel examiner? 1 Yes 2 No 27. Manner of Deeth 1 Natural

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

investigation 6 Could not be determined

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

1 Tyes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signature end title of certifier

Attention my

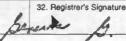
29c. License number 70/6 29d. Date signed (Month, Day, Year) December 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles St., Sete 4105 Bilthon, my 21704 Lennetz M. Green, 00

31. Date filed (Month, Day, Year) State Registrar

DEC 29 1999



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Mary Agnes Seifert December 24, 1999 2:20 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Manor Care Nursing Center-Rossville Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Feb. 8, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) 1□M 2♥F Months 62 Yrs. 212-34-7068 Maryland Usual Residence of Decedent 10n State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3913 Meeting House Road 21128 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specity: White 3 DWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Health Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Alphonso Patacca, Sr. Philomena Fortunato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Amy J. Seifert (daughter) 8654 Castlemill Circle, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Ø Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 6 ☐ Other (Specify) 3 Li Rilmoval from State Gardens of Faith Cem. 12/29/99 Baltimore, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

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Attac Attending

To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atte completely filled in by the fun

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The law requires that the death certificate be som

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or itema 23a and injury or other traumatic event, the Medical Examinar must and and a.

21215-0020

Baltimore, Maryland

Directo

Funeral

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical à Completed

1 Yes 2 No

1 Yes 2 No

2	6. Place of Deeth	(Check only one)
эг:	Nursing Hom	e 5 Residence

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 ☐Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? 1 Yes 2 No

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie

5 Pending investigation

6 ☐ Could not be

25. Was case referred to medical examiner?

1 Yes 2 1 No

27. Manner of Death

1. Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

Oth

29d. Date signed (Month, Dey, Year)

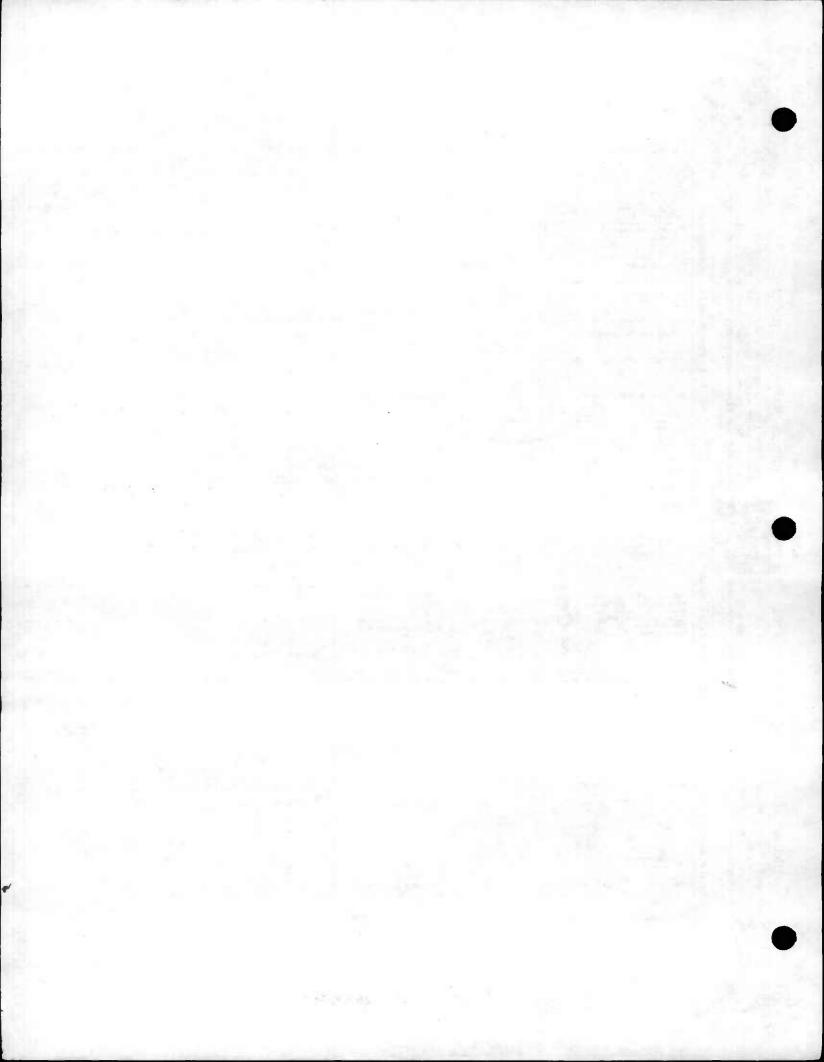
ne and address of person who completed cause of death (Item 23a) (Type, Print) Nou

31. Date filed (Month, Day, Year) DEC 29

32. Registrar's Signature

Osler DR# 203 Towson, Md 21204

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Eduard Siimsen December 26, 1999 5:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Elder Care-Long Green Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) May 30, 19 9. Birthplaca (State or Foreign Country) Paide, Estonia 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 215-30-3286 Yrs 86 Director 1913 Usual Residence of Decedent 10a. State permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show and hyginy or other traumatic event, the Medical Examinar must be nothered at each 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Scott's Haven Drive 21234-1344 Estonia Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Carpenter Carpentry Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johannes Siimsen Juulie Wilhelmine Steinberg 19a. tnformant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Marju Poldmae(Daughter) 9010 Scott's Haven Drive Baltimore, Maryland 21234-1344 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 12/30/1999 Baltimore, Maryland 21. Signature of Funeral Service Licensee Deffrey L. Gair 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515 tur or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. 23a. Party. Erfer the diseas shock, or hear failule. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) atheresolentie cardinasarla diseau /Medical 20 4 Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use es the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury Due to (or as e consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No metastetis signed t Prostate concimme py Records, 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Was en eutopsy performed? anemia atrial librillation 1 ☐ Yes 2 No 1 ☐ Yes certificate Division of Vital or Attending Physician: 25. Was cese referred to medicel examiner? funeral director. 26. Place of Deeth (Check only one) 1 Yes 2 No Other: Sursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation To the Hospital or Attending within 24 hours aftar death. To the Funeral Director: Afta completaly filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier

State Registrar

DHMH 16 Rev 6/95

and title of Setifier

P.

Month, Dey, Year)

DEC 2 9 1999

J'mith.

ddress of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signeture

29b. Signally

8709 Hardord Road

29c. License number

D-1495

Darks

Baltimore, Md.

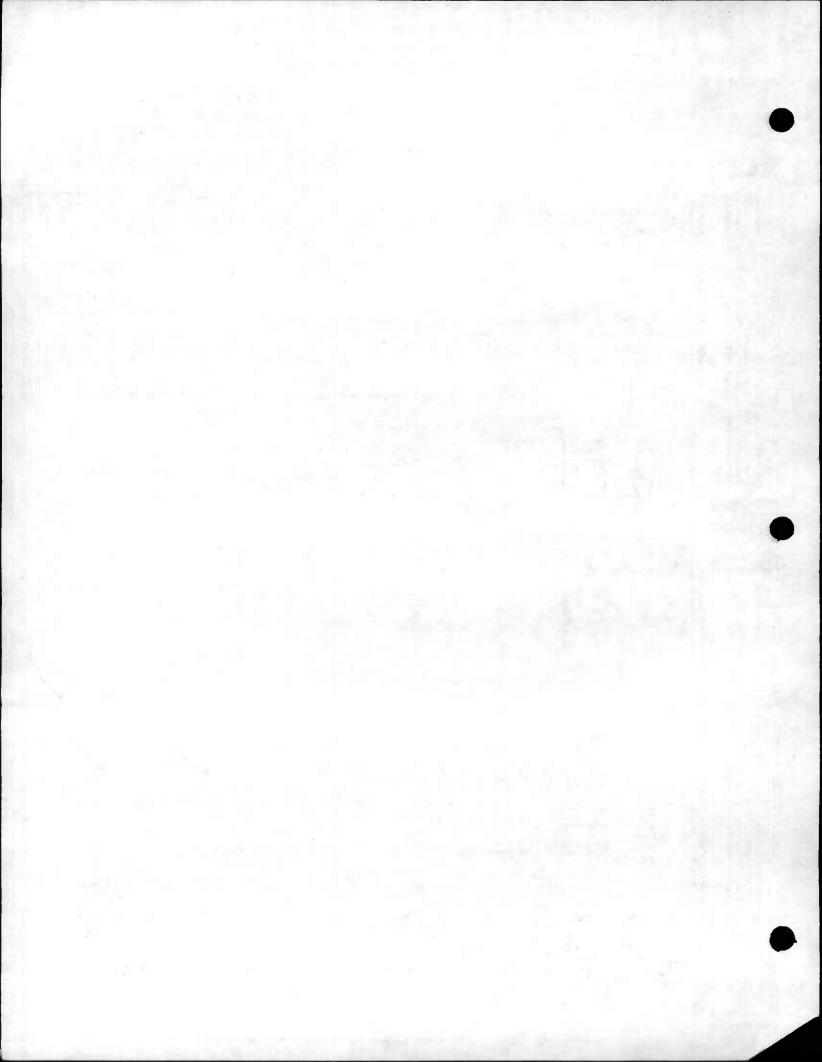
29d. Date signed (Month, Day, Year)

12-27-99

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

F	AUL JOHN AMEND I	SCHAEFER TEMS: #23 PART	State of Maryland, 27 PER ME	d / Qepartin O <i>Certific</i>	entof! cate of	Death	Mental Hy	giene 9 9	4	0767.	
r	Physician	1. Decedent's Name (First, Middle, Las	2. Date of Dec Month		Year	3. Time of Death					
Š.	/Medical	PAUL JOHN SCHAEFER						22, 199		0745 AM	
	Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Loca 1700 CONNER PLACE FOREST HII						The state of the s			
	Funeral Director	216-54-22/5	9x 7. Age (In yrs. I		Inder 1 Year oths Days		8. Date of Birt (Month, Da July 9	, Year, 1953	9. Birthpl Coun Mary	laca (State or Foreign try) Land	
	pue &	Usual Residence of Decedent 10a. Stata 10b. County	10c. City	y, Town or Location	1				10	0d. Inside City Limits	
	A she	Maryland Harfor	d Fo	rest Hil	1					1 ☐ Yes 2 No	
	r 28a	10e. Street and Number			f. Zip Code			10g. Citizen of What Country?			
	th with	1700 Connor Place 21050						U.S.A.			
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Department of Health and Mertall Hygiene. Theorem: If them 27 is marked other than "natural", or thems 23a or 28a-f show eny Injury or other traumatic event, the Medical Evant ver must be notified all once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	I.S. I3. Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puarto 1 ☐ Yes 2 ☑ No Specify:			pecify Yea or No- o Rican, etc.)		, Whita,		
21215-0020	tural tural	15. Decedant's Ed	Yaar or Dates:	Usuat Occu	netion		16b. Kind of Bus		ite		
212	led within 72 ho tygiene. Nor then "netun if, my Med cell Completed	(Specify only highest gra-	de completed)	(Give kind o		during most of wor	king	TOD. THIS OF DU	JII 1233 W 10	ustry	
212	d with giene	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ years	Dentis	Dentist			Dentist	ry-S	elf Employed	
pu	tal Hygin d other event, the Co	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Sumame	9)		
yla	should the number of marked urmatic	Paul Michael Scha				Helen I				the state of	
Maryland	12 sh h end r is m treum	19a. Informant's Name/Ralationship (7				t and Number or Ru					
	1 end Health ern 27 ither tr	Michele V. Schaef		1700 (lace of Disposition		Place,	Pate	Hill, M		1050	
nor	Peges net of nt: If It iry or o	1 X Burial 2 ☐ Cremation	Removal Irom State	emetery, crematory	or other pla						
altimore,	artme ortam Injury	4 Dohation 5 Other (Scientification) 21. Signature of Funeral Service Licen	THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW			Gardens	12/2//99	Bel Ai	r, M	aryland	
B B	permit. Departr Importu eny Inje	1/2.0 1		Sch: 610	imunek W. Ma	Funeral cPhail Ro	oad, Be	1 Air, M		1014	
		23a. Part1. Enter the disease, or some shock, or heart lailura. List only of	plications that caused the death one cause on aach lina.	n. Do not enter the	mode of dyi	ing, such as cardiad	or respiratory ar	rest,	i	Approximate Intervat Between Onset and Death	
	Physician /Medical	tmmediata Causa (Final HEMOPERITONEUM									
	Examiner	disease or condition resulting in death)									
	je je		RUPTURE	OF PSEU	DOCYS	ST OF PA	NCREAS	IN ASS	SOCI	ATION	
	cate be executed physicien and the buriel-transit calcal Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of):									
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87	8 £ ± D										
9 X	ires that the deeth certific signed by the ettending pld be detached for use as by Physician/Me		d								
Вох	eften 3 for u	Dati Ohar India	a contribution to doub but not continue in the underlying and in the contribution in t						1		
o.	the cachec	Part II. Other significant conditions co	nditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown			
o.	as that igned be del										
Vital Records,	been sign should the						24a. Was	an autopsy rmed?	ava	ere autopsy lindings allable prior to	
ecc	has be ge 2 sh								of o	mpletion of cause deeth	
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ot	this of the sel direction To	ALM THE ZLING] NOO			denca 6 □Othe		1)	
Division of	After funer funer	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	iryat ork?]Yes 2 □ No	28d. Dascribe r	now Injury occurre	ea .		
1SI	tal or Attending P rs after death. el Director: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be				,100 2 100	28f. Location (S	Street and Numbe	er or Rura	I Route Number,	
2	din b	4 Homicide	building, etc. (Specify				City or Tov	vn, State)			
	To the Heaptal or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Phy (Check only one) Medical Exam	raician: To the best of my know Iner: On the basis of axaminati end manner stated.	wledge, death occu ion and/or investig	rred at the ti ation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	causa(s) and mai date and placa, a	nnar as st nd due to	ated. the cause(s)	
	Within To the comp	29b. Signature and title of condition	L 1	1	29c. Licen		TELL!	29d. Date signed	(Month, I	Day, Year)	
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		30. Name and addless of person who,	Ompleted cause of death (Item								
		JOSEPH!	restamer 1	11 Penn S	Street	, Baltim	ore, Mar	yland 21	201		
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signat		Ano.						
	Registrar		200 Paragardo	1 1	£ +2, 12.	25 1					

VH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician Mildred H Sargent 24, 1999 December 3:30 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Laurel Prince George 8. Date of Birth (Month, Day, Year) Feb. 20, 1919 If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours 80 Yrs Director 217-38-3281 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinations to confine the motified. 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Howard County Maryland Savage 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8890 Washington Street 20763 USA Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Winfield Scaggs Viola Krause 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Sargent/Son 8877 Washington Street, Savage, Maryland 20763 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/99Elkridge, Maryland Meadowridge Mem. Park rvige Lig 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 234 fant. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, hock, of heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) for use as 1 signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings eveileble prior to completion of cause of death? been si Completed 24a. Was an autopsy is certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No Investigation deeth. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter de To the Funeral Directo completely filled in by th 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D39532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

strar DEC 2 9 1999

Timothy P.
31. Date filed (Month, Day, Year)

Claim MD 321 Prince George St. Laure MD

32. Registrar's Signature

Service George St. Laure MD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth Sulli van **Physician** Stanley DECEMBER 25, 1999 9:30AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 1002 SPRING GATE ROAD CATONSVILLE BALTTMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax Birthpleca (State or Foreign Country) **Funeral** Months Deys 1XM 2 F Yrs. 75 218-14-2616 Director 3/8/1924 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow MD BALTIMORE CATONSVILLE 1 Yes 2 XNo Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1002 SPRING GATE ROAD 21228 Nema 23a U.S.A. Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S.
Armed Forces?

1XX es 2 □ No
If Yes, Give
Year or Dates: WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) i Hyglene. hyglene. other than "netural", or her 1 Never Married 20 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 TRAIN ENGINEER B & O RAILROAD parmit. Peges 1 and 2 should be file Department of Heelth and Mantel Hy Important: If Itam 27 le marked othe any injury or other treumatic event page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARD THOMAS SULLIVAN MARY ELIZABETH (NORWOOD) 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BETTY SULLIVAN 1002 SPRING GATE RD APT 2 CATONSVILLE, MD 21228 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete NOBurial 2 ☐ Cremetion 3 ☐ Removel from State 12/29/99 4 ☐ Donetion 5 ☐ Other (Specify) SPRINGFIELD CEMETERY SYKESVILLE, MD 22. Name and Address of Fecility re of Funeral Service Lice WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 23a. Pert1. Enter the disease, or complications may caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): and P.O. Box 68760, attending physician for use as the buria Physician/Medical Due to (or es e consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed the should be det Records, à 24b. Were eutopsy findings eveilable prior to Completed 24a. Was an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 2 Accident deeth. 1 Yes 2 No 24 hours after deeth e Funeral Director: / pletely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

Q

State

29b. Signeture end title of certifier

DHMH 16 Rev 6/95

ss of person who completed cause of death (Item 23a) (Type, Print)

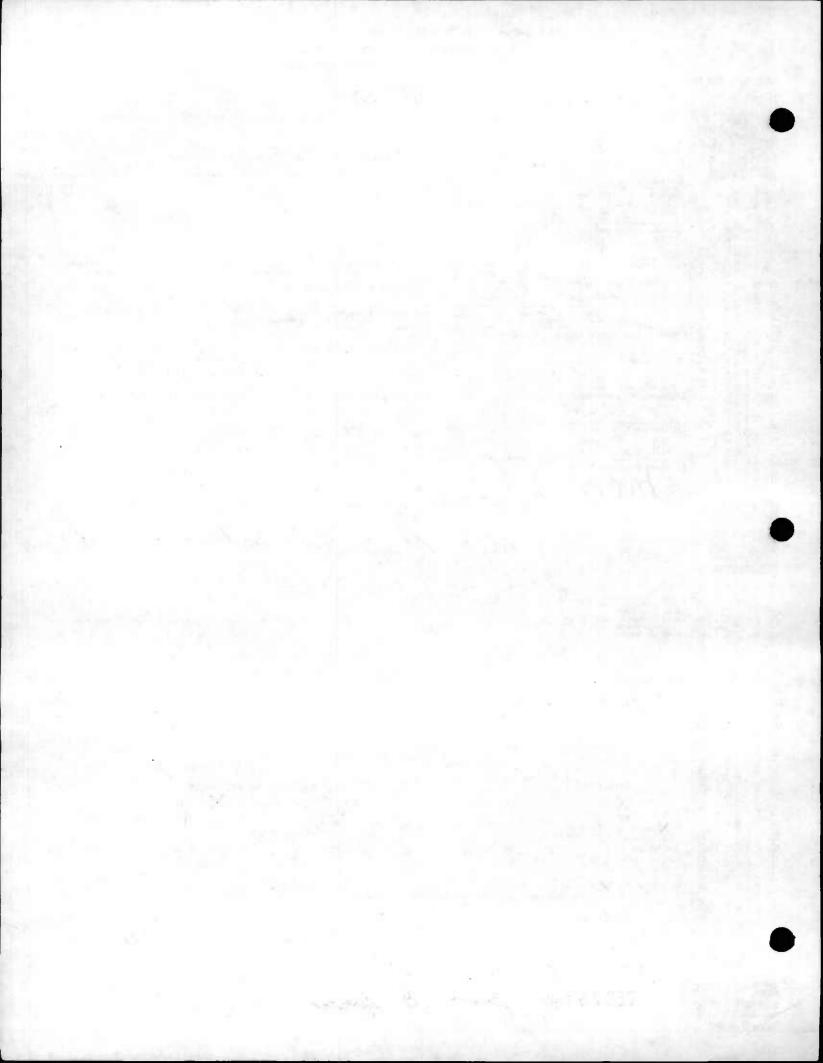
32. Degistrar's Signeture

29c. License number

oaks

D31726

29d. Date signed (Month, Day, Year)



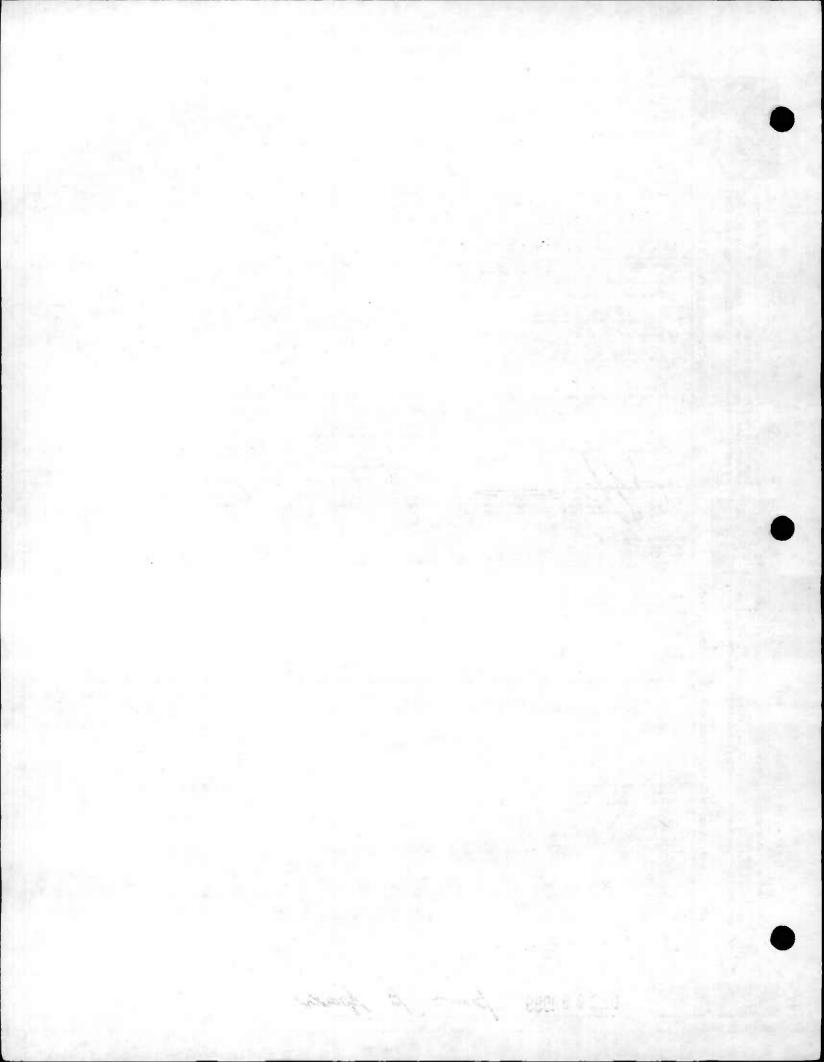
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Murie 25, umner Dec 2:15 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia
If Under 24 Hrs. Howard 5. Social Security Number If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** 1□M ŽCXF Days Yrs. 129-16-8719 Director Feb. 2, 1928 New York Usual Rasidence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits A or 28a-f show 1 ☐ Yas 2 ☑ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5007 Mountain Circle Apt. 1 "natural", or items 23s 21044 permit. Pages 1 and 2 should be filed within 72 hours effar deeth Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than 'natural', or here 28 any injury or other traumatic event, the Medical Exeminance 2000s. U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Black, Whita, etc. 11, Merital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) Years Elementary/Secondary (0-12) 3 Disability Advocate Public Service 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be George Sumner Cora Proctor 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 6242 Wild Swan Way Roseann McConnell Columbia, MD 21045
Data 20c. Location - City or Town, State 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Oak Grove Cemetery 12/30/99 Medford, Massachusettes 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungal Service Licensee 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast.

Approx. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Finel disease or condition rasulting in death) hours Examiner Due to (or as a consequence of): Physician/Medical Examiner nepatitus or Attending Physicien: The lew requires that the dagth certificate be executed the burlal-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as e consequence of): Box 68760, Dua to (or es e consequence of): for usa as P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown been signed by should be detec heart Longestive Division of Vital Records. Àq 24b. Were autopsy findings aveilabla prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No cartificate : After this cartifica funaral director, p Be 25. Was case rafarred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending invastigation Hospital or Attending 1.24 hours after death.
 Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide La Certifying Phyeician: To the best of my knowledga, daeth occurred at tha time, dete and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to tha ceuse(s) and mannar stated. 29e. Certifier (Check only one) within 2 ş 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number pm 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Ellicott City MD MO 9501 Annapoly beller 011

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year) DEC 2 9 32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 27, 1999 8:30 A.M **Physician** Betty G. Schwitzerlett /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosedale Introduction Min. Sedale (Birth (Month, Day, Year) Aug. 14, 15 4c. County of Death Examiner Franklin Square Hospital Center

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) It Under 1 Year Baltimore 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs 1930 Director 212-28-4826 Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 ahould be filed within 72 hours aftar death with the Manylan Department of Hauth and Mentel Hyglene. Important: if hem 27 is marked other than "natural", or forms 23a or 28a-f show any injury or other treumatic avent, the Medical Examiner must be notified at Maryland Baltimore Middle River 1 ☐ Yes 200No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1322 Sleepy Hollow Lane 21220 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married chwitzenlett, Be Ballimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Western Electric Machine operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence E. Green Regina Purty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Smith II (son) 929 Wampler Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/99 Baltimore, Maryland Glen Haven Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bruzdzinski Funeral HomeP.A. 1407 Old Fastern Avenue, Essex, Maryland 21221 23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart feilure. List only one cause on each line. Physician Thrombosed artificial mitral valve with Immediate Cause (Final disease or condition resulting in death) /Medical right heart failure 5 days Examiner Due to (or as a consequence of): physicien and the buriel-transit The lew requires that the death certificate be assecuted Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): for use es signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 No 1 Yes 2□ No 1 X Yes Vital Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA ō th a After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Division Attending 1 ANatural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

State Registrar

(Check only one)

29b. Signature and title of certifier

Chris

31. Date filed (Month,

Park

C 2 9 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin.

32. Registrar's Signature

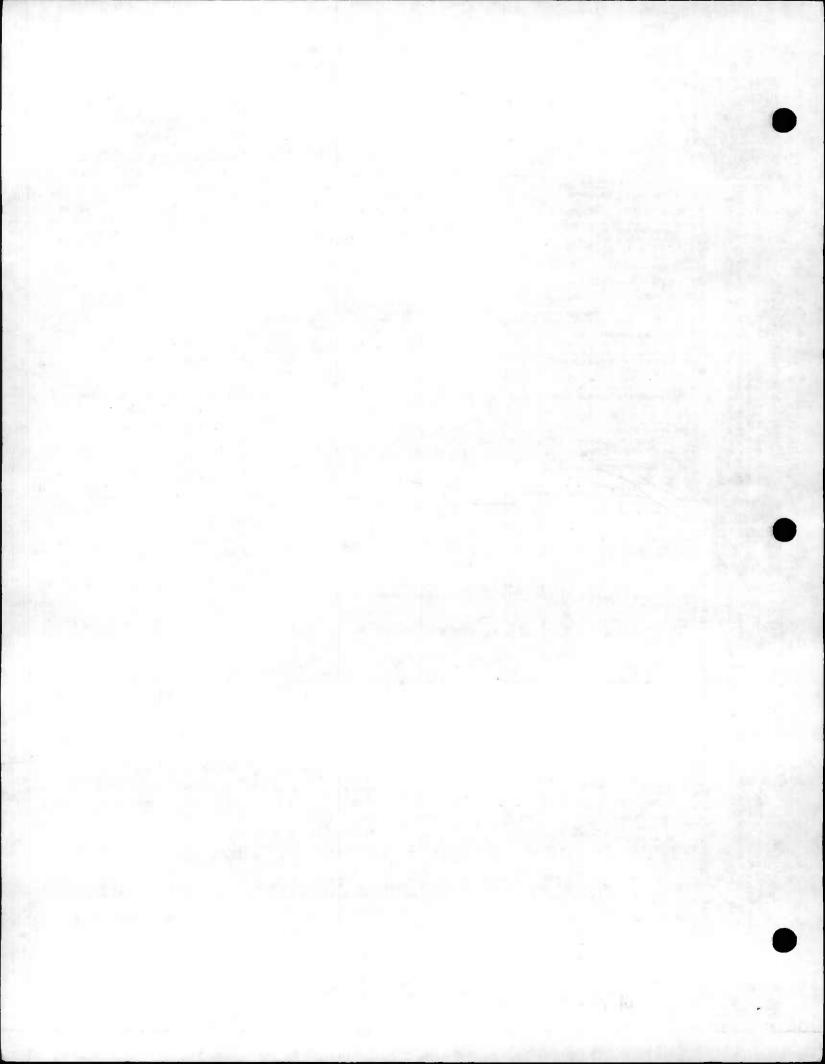
DHMH 16 Rev 6/95

29c. License number

square Drive Baltimore, MD 21235

29d. Date signed (Month, Day, Year)

December 27,1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 40772 State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Earle 8:00 Am 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore North Ave ymington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 20 F Yes Director 233-34-5432 Usual Residence of Decedent 03-07-1920 W. Virginia permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic avent, the Medical Examinar must be notified at pine. 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 North Symington Ave. 21228 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates: WW T T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2□ No Specify 3 Widowed 4 Divorced WW II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Year Purchase Agent Flooring Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Isaac Samuel Shaffer Ida Virginia Whetzel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois C. Shaffer (Wife) 23 N. Symington Ave. Catonsville, MD 21228 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Balt.-Wash. Crematory 12-28 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edomdson Ave. Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shockly or heart bailure. List only one cause on each line. Immediate Cause (Finel disease or condition rasulting in death) Carcinoma Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investination in my opinion death occurred. 29a, Certifier Medical (Check only one) **: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Attending Physician: To the Hospital or Attanding within 24 hours after deeth. To the Funeral Director: Afte completely filled in by the funeral present of th

Registrar

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P.O. Box 68760.

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Examiner

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brecher

29c. License number

DO 1317

Bultimore

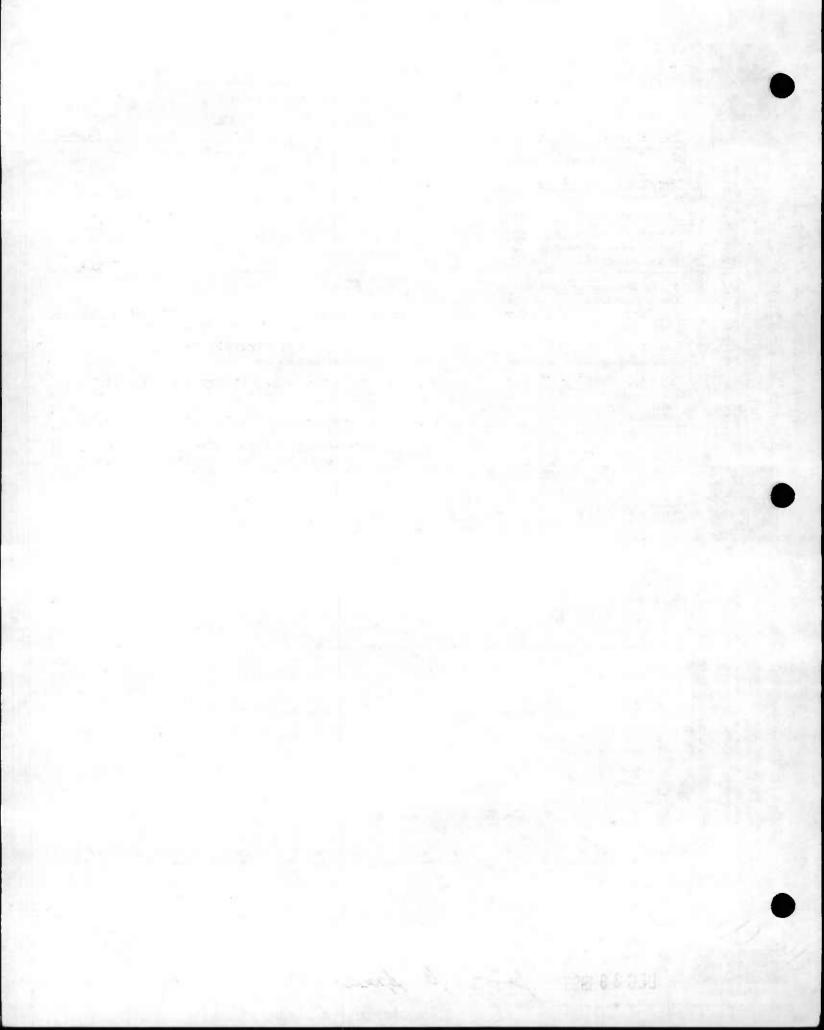
29d. Date signed (Month, Day, Year)

Dec 27, 1999

21228

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Earl Randolph Smith Decembe /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GIEN BURNIE HOSPITAL AACOUNTY ARUNDEL If Under 24 Hrs. 8. Data of Birth (Month, Day, 5. Sociel Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Vear) Days 180 M 2□ F Yrs. 215 09 8654 84 Director June 17,1915 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 227 Arundel Road Rems 23a 21122 U.S. Funeral 12. Wes Decedent Ever In U,S.
Armed Forces?
1 월 Yes 2 □ No
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Yeer or Detes: Ŵ.W. II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marltel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 8 1 Yes 2 No Specify: ò Specify: 3☑ Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Hygiena. Elamentery/Secondery (0-12) College (1-4or 5+) Machinist Bethlehem Steel 11th Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any lijury or other traumatic event ands. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Randolph Smith Annie Korneman 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly Belschner 234 Stonecroft Road Baltimore, Maryland 21229 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removel from State Lorraine Park Cemetery 12/30/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral Service Licansee 22. Name and Address of Fecility Gonce Funeral Home P.A. ranceouper 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** fmmediate Ceuse (Finel disease or condition rasulting in deeth) /Medical Examiner Dua to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, laading to immediate cause. Entar Underlying Cause (Disease or Injury that initieted events resulting in death) Lest use as the burial-tran Due to (or es e consequence of): P.O. Box 68760. Due to (or as e consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 dunknown 1 ☐ Yes 2 ☐ No Records, Be Completed by page 2 should be 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy parformed? completion of causa of daath? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this cartificate of Vital or Attending Physician: funeral director, 25. Wes case rafarred to medical 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 2☑ER/Outpatient 3□ DOA 27. Mannar of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c, Injury at Work? Aftar Division 1 Natural 5 Pending death. 1 Yas 2 No investigetion 2 Accidant the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homlolde completely filled Hospital Certifying Physician: To tha best of my knowledge, deeth occurred et the time, data end place, end dua to tha cause(s) and manner as steted.

2 Medical Examiner: On tha basis of examination and/or Investigation, in my opinion, death occurred at the tima, data and place, and dua to tha ceusa(s) and menner steted. Medicai 29a. Certifier (Check only one) \$ 29b. Signature and title o 29c. License number 29d. Dete signed (Month, Dey, Year) 0

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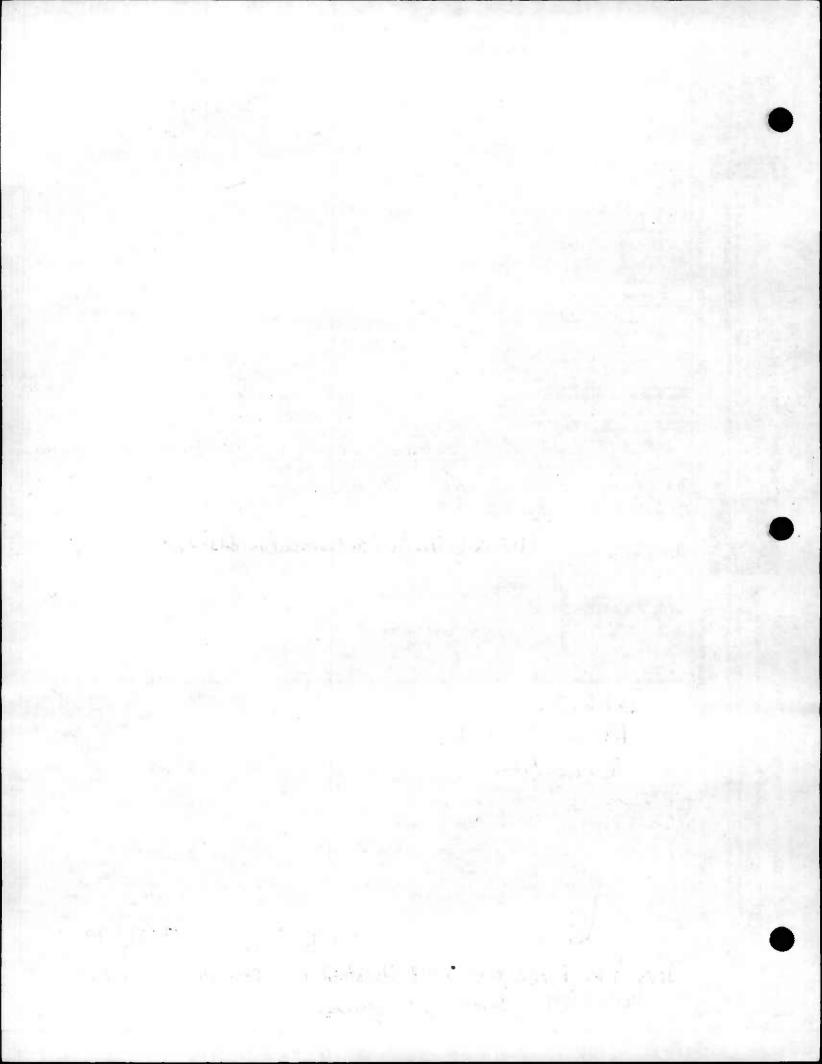
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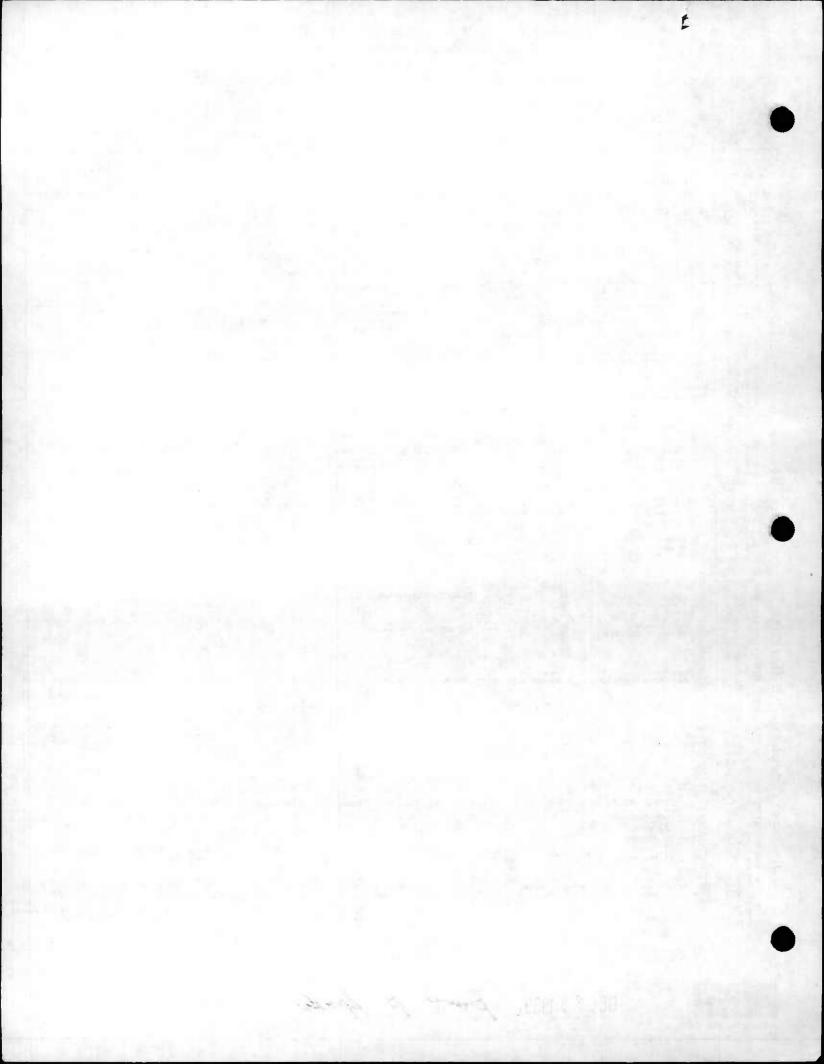
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Data filed (Month, Day, Year)
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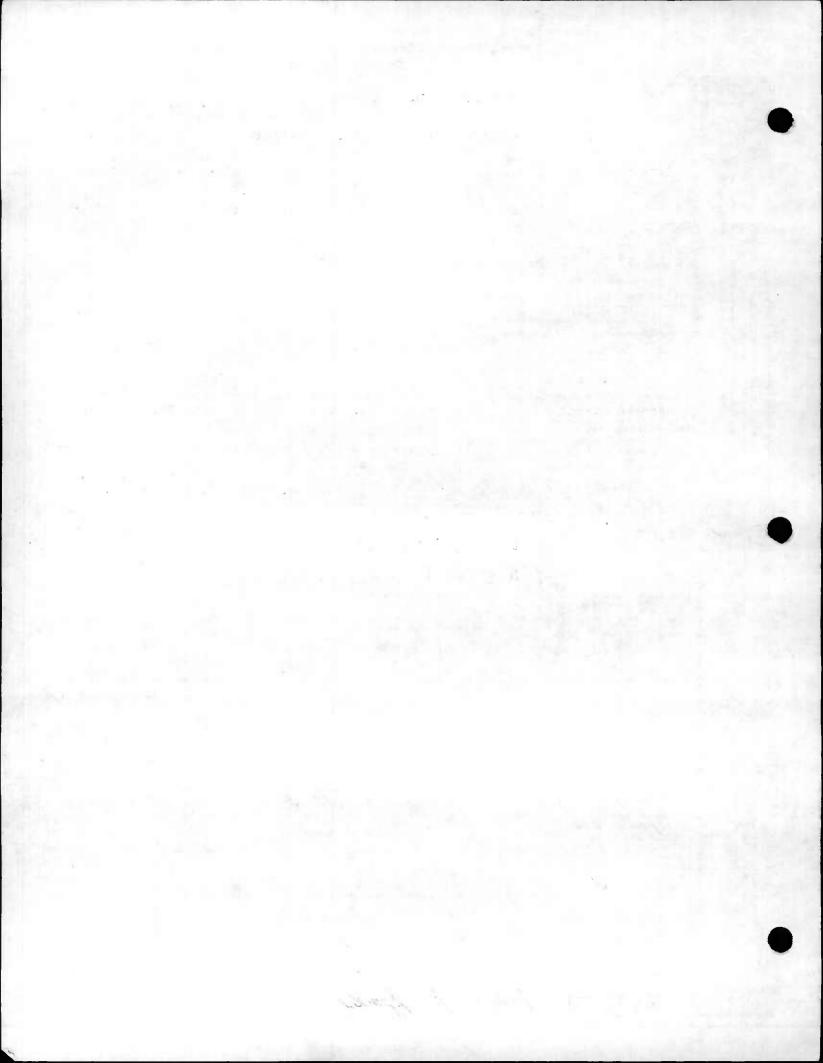
32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Certificate of Death	Reg. No.								
Physician /Medical	Decedent's Nema (First, Middle, Last) Lillian M. Skaggs	2. Dete of Deeth Month Dey Yeer 3. Time of Death Dec 24, 1999 1:50 PM								
Examiner	4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Lo									
	Genesis Heritage Meridian Eldercare Ctr. Dundalk									
Funeral Director	5. Sociel Security Number 217-22-5129 G. Sex 1 M 2 XF 88 7. Age (In yrs. last birthday) Yrs. 88 Hours Min. 1 Under 1 Year if Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 21,1911 9. Birthplece (State or Foreign Country) West Virginia								
the Maryland 28a-f show notified at rector	10a. Stata 10b. County 10c. City, Town or Location	10d. inside City Limits ore City 1 N Yas 2 □ No								
\$ 5 A D	10e. Sfreef and Number 10f. Zip Code 21214	10g. Citizen of Whet Country? United States								
020 us after death v at, or them 23s Esambler must by Funeral	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Nevar Married 2 □ Married 1 □ Nevar Married 2 □ Married 1 □ Nevar Married 2 □ Married 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:									
Maryland 21215-0020 d 2 should be filed within 72 hours after th and Mental Hyplems. 7 is marked other than "natural", or fut traumatic event, the Medical Examina To Be Completed by Fu	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 6 Years 16a. Decedent's Usuel Occupation (Give kind of work done during most of work) iffe. DO NOT use retired) HOUSEWIFE	16b. Kind of Business/Industry								
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and show	19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rura									
	Donald Skaggs / Son 4032 St. Augustine La	ne Dundalk, Maryland 21222								
altimore, mit. Pages 1 ar partment of Hea portant; if Hem.; y Injury or othe cs.	20e. Method of Disposition 12 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Gardens of Faith Cemetery	Date 20c. Location - City or Town, State								
Balti permit. Departm Importa any inju	21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral	Home of Dundalk, Inc.								
	7922 Wise Ave. Dundalk, Maryland 21222 23a. Perl 1. Enter the disease, or complications the coused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximate Intervel Between									
68760, rificate be executed triciate be executed as the bunial-transit as the bunial-transit Aedical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) e. DEHYDRATION Due to (or as e consequence of): ACUTE REMAL FAILUR Due to (or es a consequence of): Couse (Disease or injury that initieted events resulting in death) Last DEHYDRATION Due to (or es a consequence of): Couse (Disease or injury that initieted events resulting in death) Last	E								
P.O. Box 6 hat the death certific d by the attending personned for use as										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
al Records, P.O. Box The law requires that the death centale has been signed by the attending, page 2 should be detached for use. Completed by Physician/M		24a. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of causa of death?								
Vital Re- idlen: The lay certificate has rector, page 2		1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No								
f Vita ystcian: s certifica director.	examiner?	h (Check only one)								
Physic this ce ral dire	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 Othar (Specify)								
or Attending Interdeath. Director: After in by the funerertification	1 Neturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Hospital 24 hours 24 hours 5 funeral etely filled	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one)									
To the comple	29b. Signeture and titla of certifier 29c. License number	29d. Deta signed (Month, Day, Year)								
F 3 F 6	Carin Day 1 June M.N. N971CE	12/21.188								
	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)	11-4/11								
6	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	e Baltinere MD21222								
State Registrar	DEC 2 8 1999 Service Signature Sports									

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item #5 per fh g782 4/24/2000 ah Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Evelyn M. Steyer December 25, 1999 11:15 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Perring Parkway Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8. Months | Days | Hours | Min. | 12/07/15/1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218 05 7133 213-74-2077 Usual Residence of Decedent 1 M 2 TF 92 Yrs Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f ahor Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1801 Wentworth Road 21234 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 ☑ No Specify: Specity: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othn any injury or other traumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) P. John Semft Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John Steyer 3918 Wilke Avenue Baltimore, Maryland 21206 20b. Placa of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 12/29/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 Approximate Interval Between Onset and Death leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac 1da Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 68760 Physician/Medical the Due to (or as a consequence of): Box P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? 1 Yes 1 ☐ Yes 200 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Naturel 2 Accident 1 Yes 2 No 24 hours efter death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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To the Hosp within 24 ho To the Fune completely fi

State

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

amer

Registrar

31. Date filed (Month, Day, Year)

and

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramen Solo Palm Mn SV 308 Svite

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

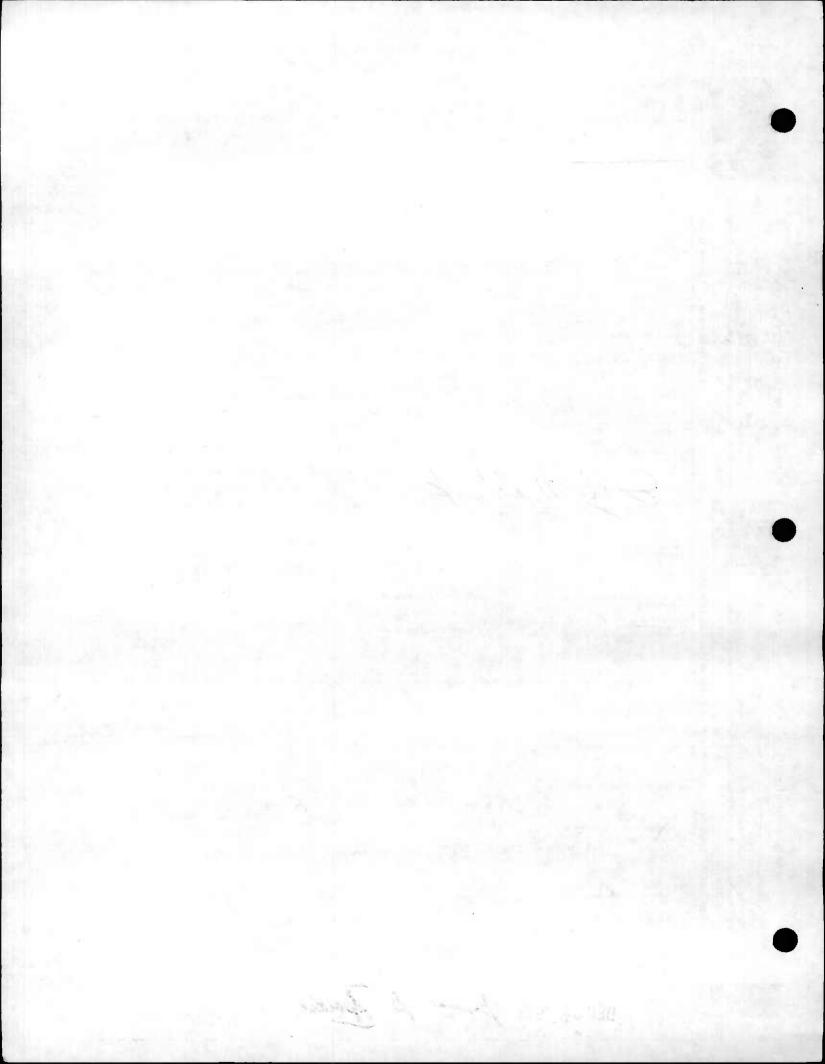
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

30641

29d. Date signed (Month, Day, Year)

821 N. Evran St. Ballone



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 130777 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** Mary L. Terry 11:15am 12 22 99 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA н. Good Samaritan Hosp. N. 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Sex Funeral 1□M 2□F Months Days 243-20-4967 77 Yrs. Director 04-05-22 NC **Usual Residence of Decedent** 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits x¹√ Yes 2 No Director MD NA Baltimore 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 3700 Seven Mile Lane Apt.B-3 21208 238 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No "natural", or itsma-11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Bace - American Indian Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 20XNo Specify: Specify: Black If Yes, Give Year or Datas: XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Grade NA Domestic other people homes permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked ofth any injury or other traumatic event place. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) 8 Charlie Highsmith Rachel Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 Juanchulla 3700 Seven Mile Lane Apt.B-3 Baltimore, Terry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata t Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Pk. Cem. 12-28-99 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the dome. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical HEROICLEMONE CARDIO VATULAN BISCARS Examiner Due to (or as a consequence of): Physician/Medical Examiner ENTEN SION attending physicien and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELLITUS Box 68760. Dua to (or as a consequence of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be det Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 No certificeta Division of Vital Te the Hospital or Atlanding Physicien:
whilin 24 hours after death.
To the Funeral Director: After this certifica
completaly filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 45 Nursing Homa 5 Rasidenca 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 1 Maturet 5 Pending investigation 1 Yas 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai To Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the 29a. Certifier on the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Data signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) Saltimon 39 Registrer's Signatura 31. Data filed (Month, Day, Year)

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State

Registrar

DEC 2 9 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40778 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death December 1999 10:03 A.M. Leona Ruth Thanner 4c. County of Death Baltimore 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospital Center Kosedala 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 XF Months Days Hours Min. Yrs. 220-22-1561 June 14, 1927 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes & No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Boulevard 21234 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4XXX ivorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Industrial MFG. Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick B. Osterman Bessie J. Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence J. Thanner (son) 406 Ivy Church Road, Baltimore, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removel from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/28/99 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Fart. Faller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Myccardial Infarction 30 Minutes

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

Dec 24, 1999

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglane.
Important: If Nem 27 is marked other than "natural", or itema 23s or 28s-1 show enty injury or other treumatic event, the Medical Examinat must be notified as one

HANNER, Laona

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

8

Funeral

Director

physicien end s the buriel-transit been signed by ahould be detac

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Examiner Physician/Medical Completed å

To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funarei Director: After this cardifica completely filled in by the funeral director; p Certification: To Medical

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Chronic Kenal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) DEC 2 9 1999

Dr. Gurminder S. Ahuja,

29b. Signatura and title of certifier

(Check only one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sports

9000 Franklin Square Onive,

ORIGINAL

D28762

Baltimore, Maryland 21237

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2 Data of Death 1999 **Physician** WILLIAMS OBERT DEC 4 NKNOWN /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ROAD WARFIELD , COUNTY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax Birthplace (Stata or Floreign Country) **Funeral** Months 425-44-3272 10 M 2 F 73 Yrs. Director NOV. 26, 1926 UNKNOWA Usual Rasidance of Decedent 10s State 10h Count 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryla Department of Heelth end Mentel Hydene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show eny Injury or other treumatic event, the Medical Examiner must be notified at buce. 1 Yas 2 No Directo COUNTY A (TLEN BURNIE MARILAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 04 KOAD WARFIELD Funeral USA. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK If Yas, Giva Yaar or Datas: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) ABORER TRUCK DRIVER WALBROOK LUMBER UNKNOWN 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) UNKNOWN UNKNOWN 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 LOVOLA SOUTHWAY, BALTIMORE, MD. 21215 (Name of Data 20c. Location - City or Town, Stata OLA ASTROP (SISTER-IN-LAW) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1⊠Burial 2 □ Cramation 3 □ Ramoval from Stata CEMETERY 12-29-99 GLENBURNIE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Name and Address of Facility JR. FUNERAL HOME BROWN JOSEPH 2140 N. FULTON AVE. BALTIHORE, HD. 21217 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervet Between Onset end Death **Physician** Immediata Causa (Final diseese or condition rasulting in death) /Medical artery disease (monary Examiner Due to (or as a consequence of): Physician/Medical Examiner use as the burial-transit Sequantially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Due to (or es a consequence of): Box 68760. The lew requires that the deeth certificate be Dua to (or as a consequence of) to P.O. 1 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2□ No 3 Probably 4 Unknown ertersion Records. à pege 2 should be 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yas this in by the funeral 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? After Neture 5 Pending invastigation To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Cartifiar

State Registrar

Pregistrar's Signatora

30. Nama and addrass of person who completed causa of death (ttem 23a) (Type, Print) Huy Papadena

29c. License number

194804

29d. Data signed (Month, Day, Year)

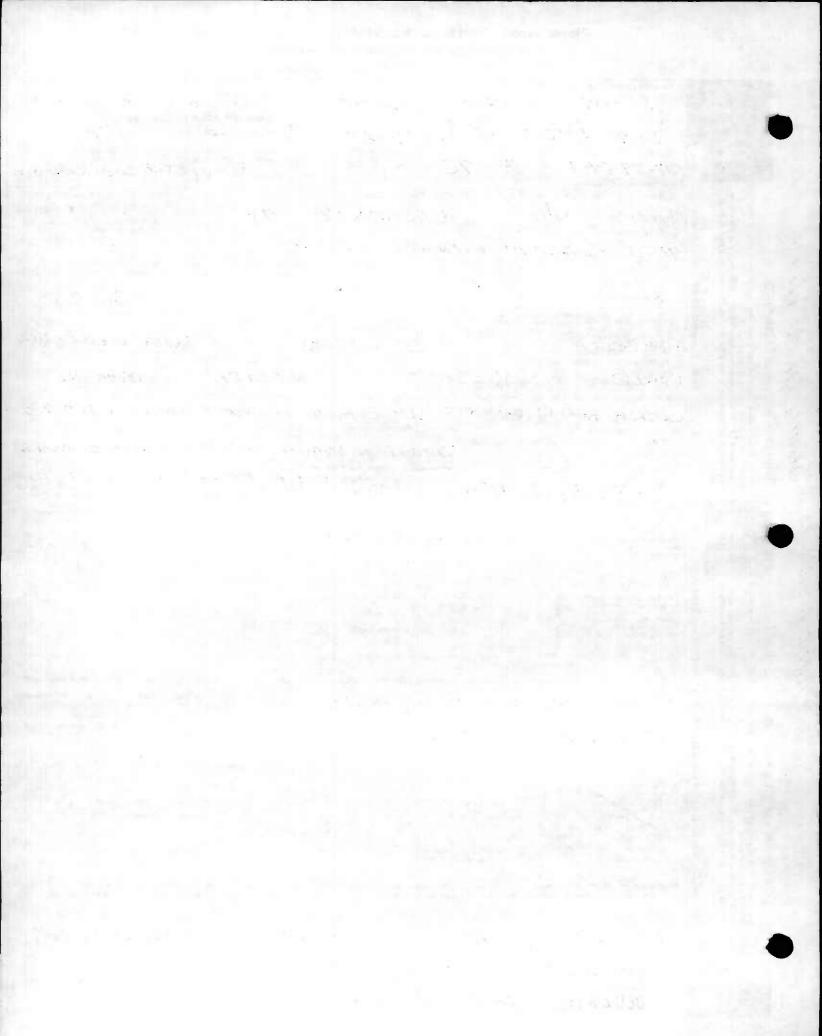
23

(Check only one)

29b. Signatura and titla of certifier

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 26. 1999 SARAH **Physician** 06:15 pm WHITE EMMA /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** HOSDITAI Battimore tf Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) Birthplace (Stete or Foreign Country) If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1□M 2 F 217-24-0481 Edoruary 3, 1929 South CAROLINA Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a. State 1 2 Yes 2 □ No BALTIMORE MARYLAND Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BOARMAN AVENUE 4120 USA. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. aroh kmma Whi 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK It Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION CUSTODIAN IQTH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REESE CARLIE ROSELEE MARTIN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Intormant's Neme/Relationship (Type, Print) HARRIS (DAUGHTER) 4120 BOARMAN AVENUE, BALTIMORE, MD 21215 GLORIA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-91-99 WOODLAWN CEMETERY WOODLAWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN JR. FUNERAL HOME BALTHORE 2140 N. FULTON AVE. ,MD,2121 25a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Gram negative Sepsis Immediate Cause (Final disease or condition resulting in death) 2 days /Medical Examiner Physician/Medical Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician end s the bunal-tran Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceuse of death? signed by the Chronic obstructive pulmonary disease 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause ot death? Coronary artery disease 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ₺ No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Be To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 E Funeral Direction of the Funeral Direction o ofter o 4 Homicide 5 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 December 2 b. 1999 30. Name and address of person who completed cause of death (Item 23a) (Type S/NQ/ +/USD/IQ/ - DY. MYCCO/IQ < 2 31. Date tiled (Month, Dey, Year)
DEC 2 9 1999 \$2. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygienen AMENDED ITEM 5.10el10f PER FH G778 12/29/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Carrie Wallace 12:46 PM 12 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ of Baltimore Battimore MD Medical System 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, 07/23/ Birthplaca (State or Foreign Country) **Funeral** Months Days Hours /32/272 1310 44 6286 Usual Residence of Decedent 1 M 2 F Yrs. Director 10a. State 10b County 10c City Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 No Director Baltimore 10e. Street and Number 1300 BONAPARTE AVENUE 10f. Zip Code 10g. Citizen of What Country? 21218 6 21230 USA 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 'natural', or items 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: Black þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) nantary/Secondery (0-12) Collega (1-4or 5+) Domestic NA VOLTIOUS (mode other parmit. Pages 1 and 2 should be file Department of Haelih and Mental Hy Important: If Item 27 is marked ofth any injury or other traumatic event DRGs. 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Brinkley Kic haydson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Road Misty Baltimore, MD. Shelia View 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, Stete 12-27-99 randallstown, 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee Baltimore Maryland 22. Name and Address of Fecility North F. H. 1101 E. 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallura. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition rasulting in death) /Medical Sepsis Examiner Due to (or as a consequence of): Physician/Medical Examiner renal tailure The law requires that the death certificate be executed anding physician and use as the bunal-transi Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): P.O. Box 68760. that initiated events resulting in deeth) Last Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No heart failure þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy sacral decubitus 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physicien: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Minpatiant 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To 1 ☐ Yes 2 ☐ No this funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Matural 2 ☐ Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated.

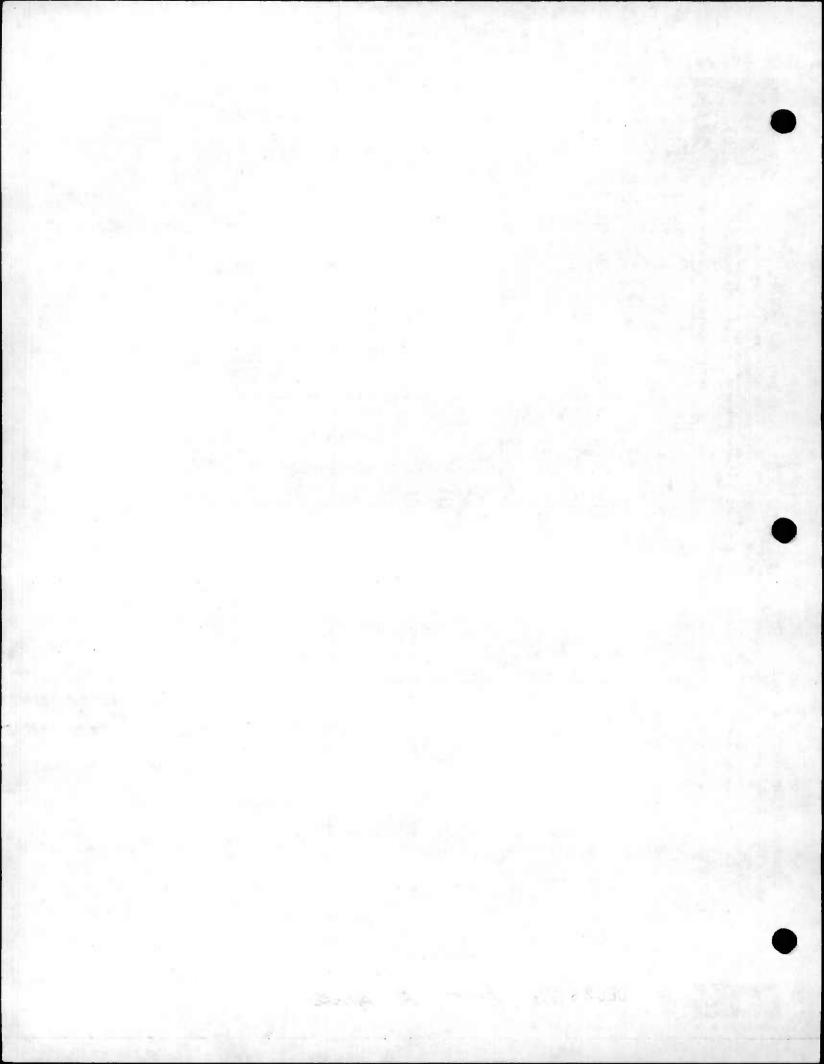
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 12/20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Univot MD Medical System MD 31. Date filed (Month, Day Year) 100 9 1999 Server State Registrar



colored Francisco

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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lor Attending Physician: The lew requires that the death certain death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Completed by										en eutopsy ormed?	ev	ere autopsy findings reliable prior to empletion of cause death?
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To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Menner of Death 1 Meturel 5 Pending (Month, Dey Year) 2 Accident investigation 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Pending (Month, Dey Year) 4 Work? 1 Yes 2 No								28d. Describe how injury occurred			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 3. Time of Death 2. Date of Death Day 25, 02-38 Am Allen Wayne Woolwine December 1999 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daeth Union Memorial Hospital Baltimore If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthpiace (State or Foreign Country) MM 2□ F Months Days Hours 217-50-3170 51 Jan. 20,1948 Maryland Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits X1√ Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3619 Hickory Avenue 21211 USA 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No tf Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puanto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Navar Married Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/industry Elamantary/Secondary (0-12) College (1-4or 5+) Manager Hanover Uniform Company 10 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Estle Woolwine Velvia Dickens 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Woolwine Wife 3619 Hickory Avenue Baltimore, Maryland 21211 Data 20c. Location - City or Town, Steta 20b. Placa of Disposition (Nema of camatery, crametory or other place) 20e. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12/29/99 Baltimore, Maryland Funeral Sarvice Lie 22. Name end Addrass of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part1. Epar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, when the disease of the death incomplete the death incomp Approximata Intervel Batwaan Onset end Death Immediata Causa (Final disease or condition resulting in death) Cardiac Dua to (or as a consequence of): lyocardial Infarction Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initieted events rasulting In deeth) Lest unknown Dualto (or as a conseque Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco usa contribute to the cause of death? Yas 2□ No 3 Probably 4 Unknown 24b. Wara eutopsy findings eveilable prior to complation of cause of death? 24a. Was en eutopsy 1 Yes 2 No 1 ☐ Yas 2 No 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending Invastigation 1 Naturat

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified a once.

Baltimore, Maryland 21215-0020

Box 68760,

Records, P.O.

Division of Vital

ettending physician and for use as the buriel-transit The law requires that the death certificete be executed signed by the e pege 2 s certificate

Examiner Physician/Medical 2 Completed Be Lo Medical Certification:

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics stell filled in by the funeral director; To the Hospital or within 24 hours eff To the Funeral DI completely filled in

> State Registrar

31. Date filed (Month, Day, Year) DEC 2 9 1999

29b. Signatura and titla of certifiar

David

2 Accidant 3 Suicide

4 ☐ Homicide

29a, Certifian

erson who complated cause of death (Item 23e) (Typa, Print)

Sishai, MD Muson M 30. Nama and address of p

6 Could not be

32. Ragistrar's Signatura

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

Union Memorial Hospital books

12 Certifying Physician: To the bast of my knowladga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the ceusa(s) and manner stated.

29c. Licansa number

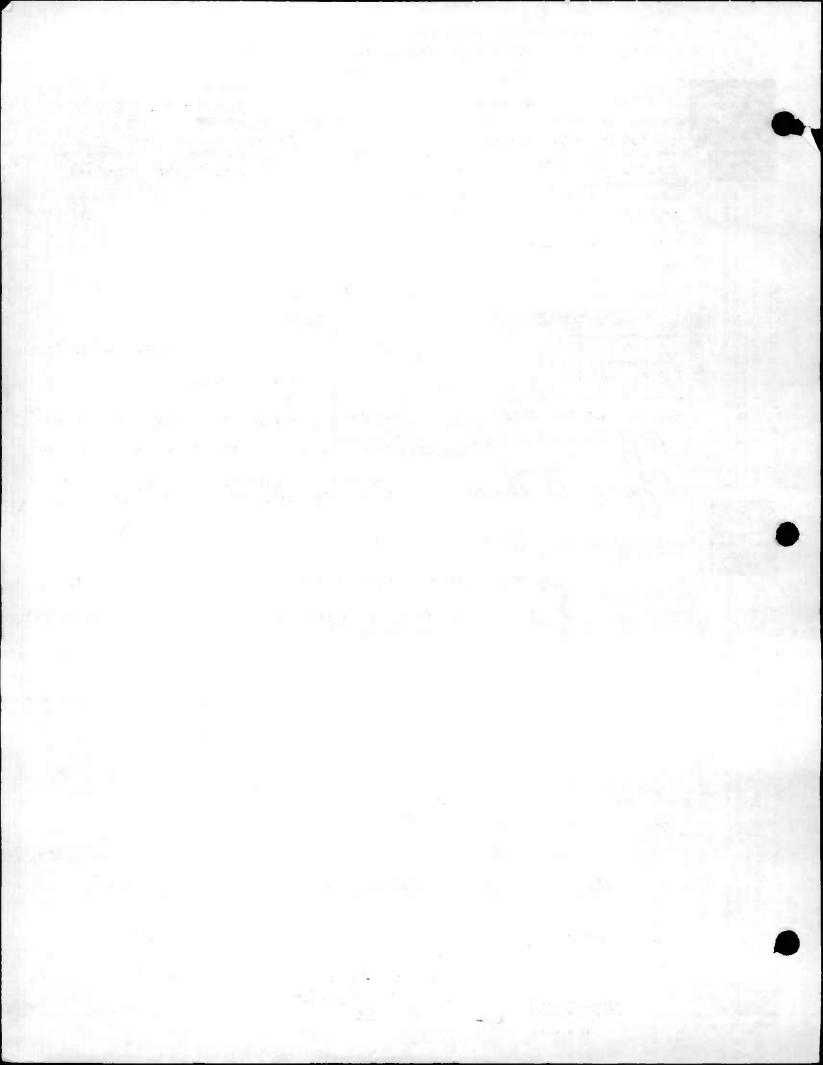
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1 Yas 2 No

28f. Location (Straet and Number or Rurel Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year)

ER Baltimore 40



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Name (First, Middle, Last, 2. Dete of Death 3. Time of Death M 6:05 ORENCE 4a. Fecility Ner ne (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BOLLIMAL If Under 24 Hrs. 8. Deta of Birth Min. 8. Month, Day, Knolls C Ale Cente 7. Age (In yrs. last birthday) SVINGTON If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 10 M 212 F 6 MARI Months Deys 1252080 93 Yrs Usuel Residence of Decedent 10a. Stete 10b. County 10c. City Town or Location 10d. Inside City Limits 1 Nes 2 No more MARY TOe. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Michue 11. Maritel Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cubap, Maxican, Puerto Rican, etc.) 14. Race Wes Decedent Ever in U,S. Armed Forces? American Indien. Black, White, etq. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2□ Married 1□ Yes 2ŪNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highast grade complated) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life, DO NOT usa ratifed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) C VAG Wh 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unt ink 19e. Informent's Name/Reletionship (Typa, Print) 19b. Mailing Address (Ştreet and Number, or Rural Route Number, City or Town, State, Zip Coda) 111Ams 20b. Placa of Disposition (Name of carnatery, prematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Dourlal 2 Cremetion 3 Removel from State 4 Donation 5 □ Other (Specify) 21. Signeture of Funeral Service License dinemason Ax on 23a. Pert 1. Enter tha diseese, or complications that causal the death. Do not enter a shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset and Deeth ardiovascular Immediete Ceusa (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, laading to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as e consequença of) Pert II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3/ Probably 4 □ Unknown 24b. Wera eutopsy findings evelleble prior to 24e. Wes en autopsy performed? completion of cause of deeth? 2 No 1 Yes 2 No 1 Yes 25. Was casa rafarred to madical exeminer? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

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7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examiner must be notified at

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Baltimore, Maryland 21215-0020

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Examiner Physician/Medical à Completed Be ٩ Certification:

is certificete has been s director, page 2 should this After t daath. To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi

> State Registrar

Medicai

27. Manner of Death 28e. Data of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Panding investigation Injury 1 Yes 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Cartifian onel

Certifying Physician: To the bast of my knowladga, death occurred et the tima, data end pleca, and due to tha ceusa(s) and mannar as steted.

Medical Examinar: On tha basis of axaminetion end/or invastigation, in my opinion, daath occurred at the time, date end place, end due to the ceuse(s) end menner stated. 29c. License number

29b. Signature end title of cartifier

Macen

29d. Date signed (Month, Day, Year)

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30. Nama end eddrass of person who complated cause of daeth (Itam 23a) (Type, Print)

PACE M 32. Registrar's Signature 31. Dete filed (Monti

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** ALTON B. WESTON December 23, 1999 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 207 Baltimore Avenue SW Glen Burnie Anne Arundel H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/24/1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** XXM 2DF Yrs. 81 216.03.5275 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Nama 23a or 28a-f ahor 1 ☐ Yes 2 XXIO Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 207 Baltimore Avenue, SW 21061 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? XXXYes 2 □ No IY Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, While, etc. 11. Marital Status be filed within 72 hours after de its! Hygiene. d other than "natural", or flem avent, the Healins Examinar! 1 Never Merried 2 X Married Baltimore, Maryland 21215-0020 WWII 1 Yes XXNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Coast Guard welder permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any Injury or other traumatic avent aloss. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Alton B. Weston Edna Taylor 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 345 Pumping Station Rd., Gettysburg, PA 17325 Diane Ward - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slete 1 XX urial 2 Cremation 3 Removal Irom State 12/29 Crownsville, MD 4 Donalion 5 Other (Specify) Maryland Vet. Cemetery 21. Signature of Funeral Service Lie FINK FUNERAL HOME, PA 22. Name and Address of Facility 426 Crain Hwy., SW, Glen Burnie, MD 21061 23a. Pertil Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory errest, shock or heart failure. List only one cause on each line. Approximele Intervel Between Onset end Death MYOCARDIAC INFARCTIO **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be assorted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): 68760 attending physician for use as the buria Physician/Medical Due to (or as a consequence of) Box P.O. P 23b. Did tobacco use contribute to the cause of death? been signed by the s Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy lindings aveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy 1□ Yes 2ENo 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2ET No this funaral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Dale of tnjury (Month, Day Year) After 1 Matural 5 Pending investigation To the Hospital or Attanding within 24 hours etter death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Dele signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who comp 31. Dale filed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

DEC 2 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month 25, CARROLL ALBERT WONTROP, SR. Dec. 6:37 a.m. 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Y Sept. 10, 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Aga (In yrs. last birthday) Year 1925 Days Hours 1 M 2 □ F Yrs. 216-20-4730 Usuat Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 1 ☐ Yas 2 ☑ No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 102 H Gwen Drive U.S.A. 21050 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Quality Control Manager Fabrication 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Frank C. Wontrop Josephine Nemec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 H Gwen Drive, Dorothy A. Wontrop (Wife) Forest Hill, MD 21050 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removel from Stata 4 Donation 5 Dother (Specify) Entombment Bel Air Mem. Gardens 12/28/99 Bel Air. Maryland 32. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signatura of Funerel Sarvice Licenses 610 W. MacPhail Road, Kredo Bel Air, MD 21014 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximata Intervel Batween Onset and Death CAncer Immediata Causa (Final disease or condition resulting in death) Luna Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yas 2 No 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 MOthar (Specify) HOS PICC 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be detarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

The law requires that the death certificate be axecuted of Vital Records, Physician: Attending

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

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permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Important: If item 27 is marked ofth any Injury or other traumatic event obtas.

Physician

/Medical

for use as the burial-transit

sata has been signed by the a page 2 should be detached if

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After

funeral director,

Physician/Medical Examiner

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Completed

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29a. Cartifian (Check only one)

Examiner

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filed within 72 hours after

Maryland 21215-0020

Baltimore,

37 Am

Canoll

Division

Medicai Certification: To To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun State Registrar

JEC Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier

and

29c. License number 1)25205

29d. Date signed (Month, Day, Year) December 25, 1999

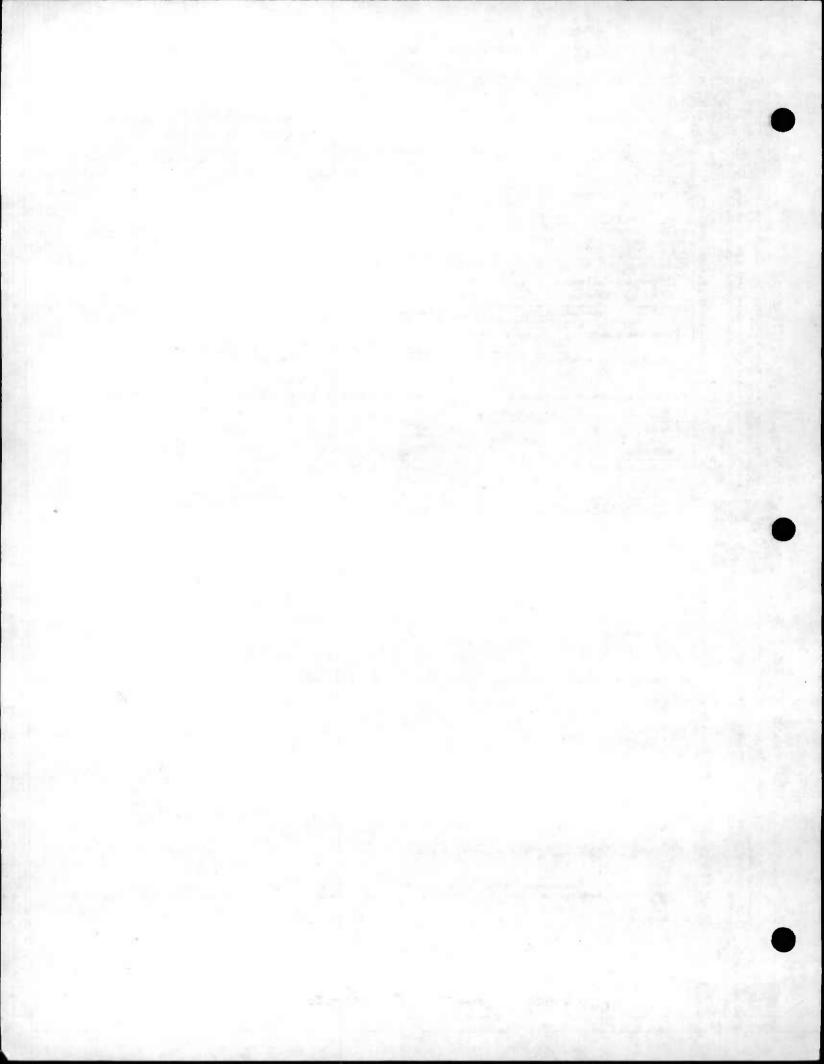
30. Name and addrass of person who complated causa of class (ttem 23a) (Type, Print)

W. A. Riley N. Charles St. Balto. md Zc20x 6201 G BMC

31. Date filed (Month, Day, Year) DEC 29

32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

9 .	1. Decedent's Neme (First, Middle	e, Last)			tificate or		2. Dele of Deeth		3. Time of Death			
cian	Penelop		Ward				Month	Dey 26	Year 72.45n			
cal ner	4a Facility Name (tf not institution	n, give street and numb	per)			4b. City, Town, or L	Decemb.	4c. County	,1999 12:45pi			
illei	Greater Baltimore Medical Center Towson							n Baltimore				
	5. Social Security Number	6. Sex 7.	Age (In yrs.		If Under 1 Yes		8. Dete of Birth	Vessl	9. Birthplaca (State or Foreign			
	213-40-1784	1 M 2 F	56	Yrs.	Months Dey	s Hours Min.	8. Dete of Birth (Month, Day, 8-18-19	43	Maryland Maryland			
_	10a. Stale 10b. County		10c. City	, Town or Lo	calion				10d. Inside City Limits			
Director	Maryland Baltir	more		Towson	1				1 ☐ Yes 2 ∏ No			
P P	10e. Street and Number				10f. Zip Code		10	g. Citizen of V	Vhat Country?			
	500 Virginia					1286		U. S				
by Funeral	11. Marital Status 1 Never Merried 2 Merri 3 Widowed 4 Divorced	If Yes Give	© No		Vas Decedent of Yes, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecify Yes or No- o Rican, etc.)		e - American Indien, k, White, etc. White			
Dete	15. Decedent (Specify only highes	t's Education		16a. Deced	enl's Usuel Occ	upation le during most of work red)	kina 1	6b. Kind of Bu	usiness/Industry			
Completed	Elementery/Secondary (0-12)	College (1-4	or 5+)					200-5	ity Doline Dest			
S	12			2	Secretar	-			ity Police Dept			
Be	17. Fether's Name (First, Middle,						ne (First, Middle, M					
9	Theodore R					FI	orence I	ronneAe				
	19a. Informant's Name/Reletionsh	hip (Type, Print)				et and Number or Ru						
	Mrs Susan Lilly	y (Sister)				w Road, L			yland 21093			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremelion 4 ☐ Donation 5 ☐ Other (St	pecify)	0	emetery, cren	silion (Neme of netory or other p /alley N	Mem. Gards			city or Town, State			
	21. Signature of Funeral Service I	Licensee S Brook	8021	1		ress of Fecility vson Funer ck Road, T			14			
Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (or	r es e consequence es e	enca of):	IBLOM	A					
sician	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the cause of death?				
Y Ph							1 Yes 2 No 3 Probably 4 Unkn					
Completed by Physician/M							24e. Wes an perform	eutopsy ed?	24b. Were autopsy findings aveilable prior to completion of cause of death?			
E							1 ☐ Yes	s X No	1 Yes 2 No			
Be C	25. Wes case referred to medical					26. Place of Dee	ilh (Check only one		28-11			
To B	examiner? 1 Yes 2 No	Hospitel:	patient 2	ER/Oulpalien	3 DOA	Where	ome 5 Reside		er (Specify)			
ation: 1	27. Manner of Death 1 Matural 5 Pending 2 Accident investig	28a. Dele of (Month,		28b. Time of lnjury 28c. Ir				cribe how injury occurred				
~	3 Suicide 6 Could n 4 Homicide determi	ined 209. PIECE OF	Injury - At ho , etc. (Specify	me, ferm, stre	eel, fectory, offic	0	28f. Location (Str. City or Town,		er or Rural Route Number,			
Certifi	On Cartificate Door att. L.		is of examinat						and due to the ceuse(s)			
edical Certification:		A and manner					29d. Date signed (Mo					
Medical Certifi	(Check only 2 Medical E	and manner			29c. Lice	nse number	29	d. Date signe	d (Month, Day, Year)			
	(Check only 2 Medical E	and manner						122	1 0			
	(Check only 2 Medical E	who completed cause	of death (Item	23a) (Type, I	00	+4560	5	12/2-	1 0			

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical
Examiner

LEE NAME: To the Hospital within 24 hours a To the Funeral Completely filled Hospital

DHMH 16 Rev 6/95

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Yeer DECEMBER 26, 1999 Lee Roy Warren 8:13PM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1 X M 2 □ F Months **Director** 232-42-9143 Sept. 25, 1922 Kentucky Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location "natural", or items 23s or 28s-f show folical Expuriner must be notified at 10d. Inside City Limits Director Maryland Baltimore Essex 1 ☐ Yes 2XXXIII 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 423 Riverside Drive 21221 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important if them 27 is marked other than "patural", or item any injury or other traumatic event, the Medical Eventines. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married XX Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by WII Specify: 3 AWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Fork Lift Operator Anchor Fence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Chester Warren Ellen Gamble 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Daniel G. Warren (son) 423 Riverside Drive, Baltimore, Maryland 21221 Dete 20c. Location - City or Town, Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Mem. Gardens 12/29/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 21. Signature of Fune at Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Park: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) ACUTE RESP, RAFORY FAILURE Examiner CHRONC OBSTRICTE LUNG DISTASE Examiner The law requires that the deeth certificate be executed use es the bunei-transi Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): DISCORF ANTEN P.O. Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 NYes 2□ No 3 Probably 4 Unknown SMOKNI Records, 9 24b. Were eutopsy findings eveileble prior to page 2 should Completed 24e. Wes en eutopsy performed? completion of cause of deeth? certificate 1 ☐ Yes 2 ☐ No Vital director 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 Dunpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No of this funeral Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) Attanding After 5 Pending investigation 1 Natural or Attanding sets of the sets 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. Medical 29a, Certifier 29b. Signature and title of countries 29c. License number 29d. Dete signed (Month, Dey, Year) DB5509 30. Neme end eddress of person y ho completed cause of death (Item 23e) (Type, Print) DR. OREST BARTOSZYK LEONARDTOWN, MD. 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 9 1999 Registrar

WARREN

ROY

99-7750-510 Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene TRACY A. WOLLSLAGER 40789 ASP AMEND ITEMS: #23 PART I, II, 27, 28 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Dev **Physician** TRACEY A. WOLLSLAGER 24 1999 DECEMBER 5:04 A /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. Date of Birth (Month, Dey, 8/1/60 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Months Hours 1□ M 2⊠ F 217-88-1437 39 MARYLAND Director Usual Rasidence of Decedent with the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ahow must be notified at 1 ☐ Yas 2 No WASHINGTON HAGERSTOWN Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 12 SOUTH MULBERRY ST. APT. 1st FLR. 21740 Funeral USA an "natural", or items Medical Exercines m 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 ☐ Yas 2 No If Yas, Giva 1 Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 15. Decedent's Education (Specify only highest grade completed) Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) 12th GRADE Collega (1-4or 5+) ADMINISTRATION ASSISTANT 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Meidan Surnama) Be CHARLES W. WOLLSLAGER BARBARA A. WHITE 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Ralationship (Type, Print) -6 BARBARA WOLLSLAGER MOTHER 1638 MYAMBY RD. TOWSON, MD If Item 27 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from Stata Department of Important: If any Injury or METRO CREMATORY, INC. 12/27/99 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
THE JOHNSON FUENRAL HOME, 21. Signature of Funeral Service Licensee

Physician /Medical Examiner

Box 68760.

P.O.

Records.

Division of Vital Hospital or Attending Physician:

The lew requires that the death certificate be axecuted

Physician/Medical Examiner by Completed Be Medical Certification: To

page

this

after death.

I Director: Af

To the Hospital within 24 hours a To the Funeral Completely filled

filled in by

29a. Certifier

1/2	8521 LOCH RAVEN BI	•	D 21286
23a Part Entar the disease, or complice hack, or heart failure. List only ona	ations that caused the deeth. Do not enter the mode of dying, such as cardiac cause on each line.		Approximata Intarval Batween Onset and Daath
Immediate Ceuse (Finel disease or condition	NARCOTIC INTOXICATION		
rasulting in death)	Dua to (or as a consequanca of):		1
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying	Dua to (or as a consequanca of):	15.75.2	
Cause (Disease or Injury c. that initiated events rasulting in death) Last	Due to (or as a consequence of):		
d.			
Part II. Other eignificant conditions control COCAINE USE	ibuting to death but not rasulting in tha undarlying causa given in Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
		24a Was an autopsy	24b. Wara autopsy findings

25. Was casa referred to medical 26. Piace of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 1 Nas 2 No 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify)

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death of and mannar stated.

available prior to 1 Yas 2□ No 1 PYas 2 No

27. Manner of Death 1 □Natural 2 □ Accident	5 Pending invastigation	28a. Dete of Injury (Month, Day Year) Found:	Found: M	28c. Injury a Work? 1 🗆 Ya
3 ☐ Suicida 4 ☐ Homicide	6 Could not be determined	28e. Place of Thjury At h building, etc. (Speci	oma, fampi subo fac by) HOUSE	tory, office

28d. Dascribe how injury occurred as 2 No

UNKNOWN
28f. Location (Straet and Number or Rural Route Nu City or Town, State) 1638

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and dua to tha red et the time,					

29b.	Signatura	and til	tia of certifie	1 -	1
	•	0	- 1	w	lenn
-	A STATE OF THE PARTY OF	-/-	_	*	

29c. Licansa number O.C.M.E

29d. Data signad (Month, Day, Year) **DECEMBER 24, 1999**

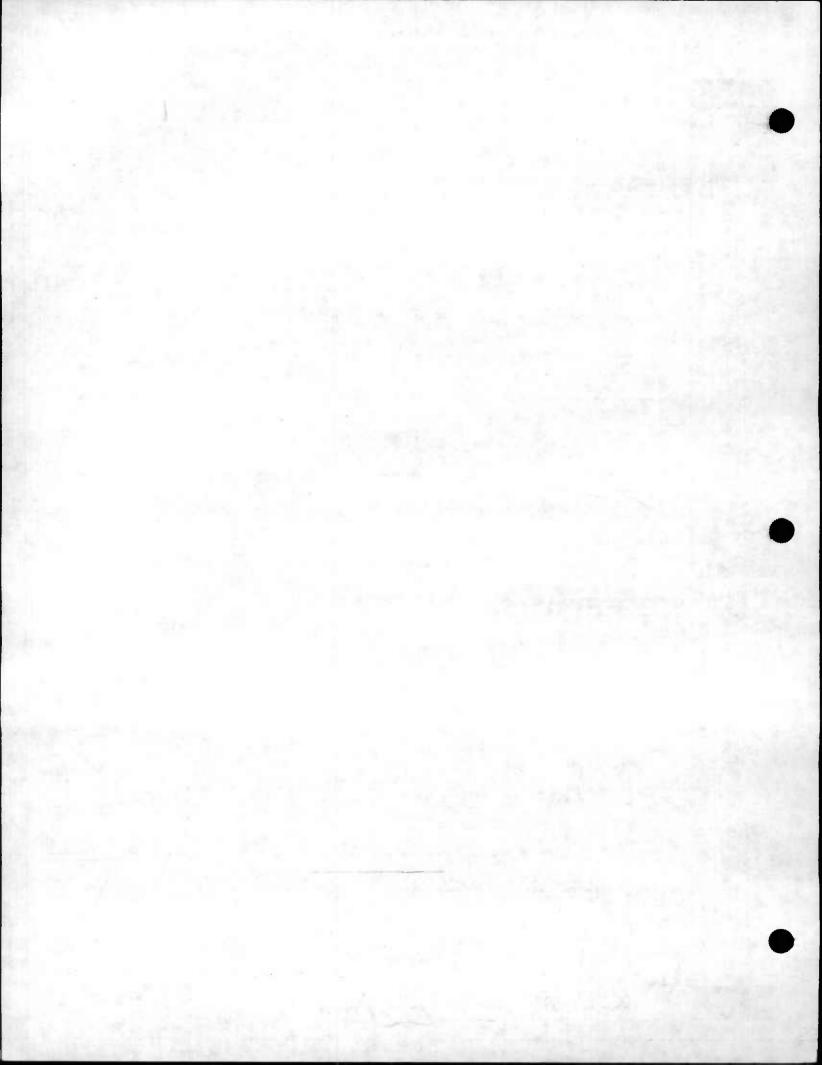
RD

ed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

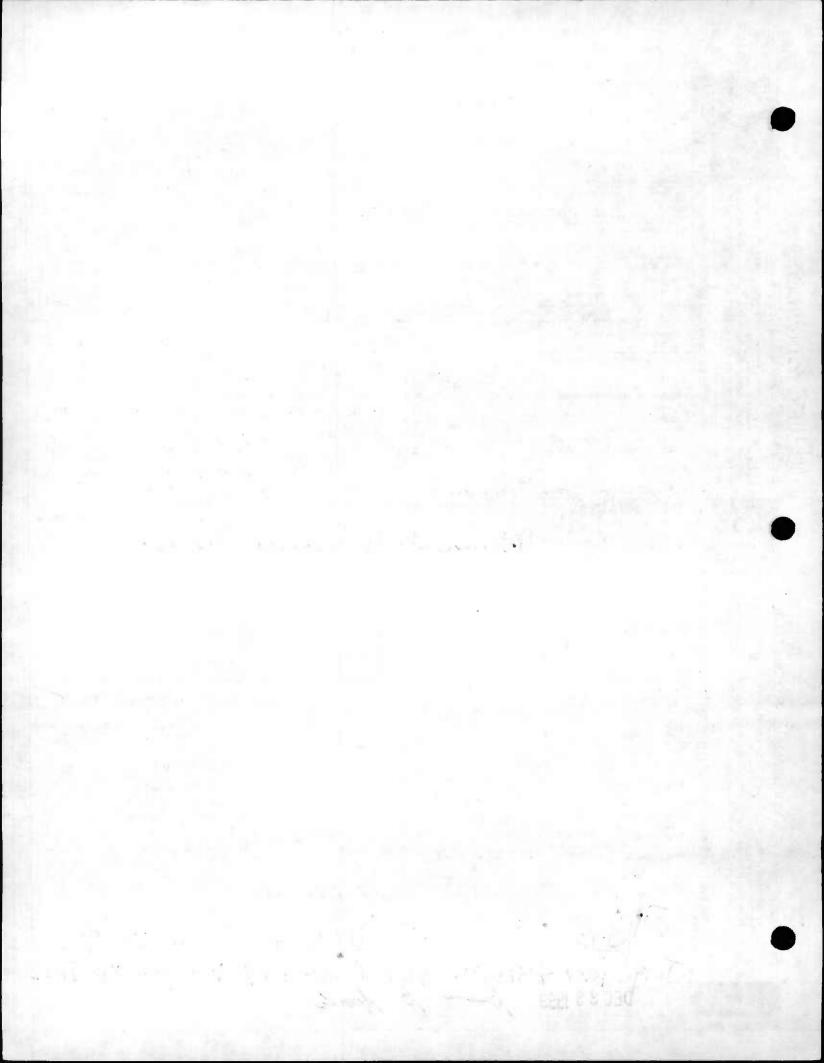
State Registrar aner gistrar's Signatura

DHMH 16 Rev 6/95



40790 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** Edward M. Waller December 27, 1999 9:54am /Medical 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner BURNIE AACOUNT OSPITAL ARUNDEL If Under 1 If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1⊠M 2□F Yrs. Director 213 03 2801 87 April 1912 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits raf', or items 23s or 28s-1 shore Examiner must be nothed at 1 ☐ Yes 2 No Director Maryland Anne Arundel Riviera Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 Wanda Road 21122 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 ☒ No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced permit. Peges 1 and 2 should be filed within 72 h. Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natui any injury or other traumatic avent, the Medical once. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Pressman Baltimore Sunpaper 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Mame Reipe Meredith Edward Waller 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kenneth Waller / Son 81 Tail Of The Fox Drive Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete Glen Haven Memorial Park 12/30/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 namuaudu 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner anding physician and use as the bunat-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760. Physician/Medical thet initieted events resulting in death) Last Due to (or as e consequence of): P.O. ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records, þ Completed 24b. Were autopsy findings availeble prior to 24a. Wes en autopsy parformed? completion of cause of death? 1 Yes 2 No 1 Yes 20 No certificate of Vital or Attending Physician: funeral director. 25. Wes case referred to medicat examiner? 8 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After Division 1 Natural 5 Pending No Hospital or Attending n 24 hours after deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide filled In 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 ho To the Fune completely fi ane) ş 29b. Signat le of certifier 29d. Date signed (Month) Day, Year) person who completed cause of death (Item 23a) (Type, Print) DIG Registrar's Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Elizabeth Elma Waldman DECEMBER 24, 1999 10:29 AM 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Deys 1 M 2 JF Yrs. 74 213-20-6424 June 4, 1925 Maryland Usual Residence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. fnside City Limits Baltimore 1 ☐ Yes 2X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? United States 21224 7151 Gough Street 12. Wes Decedant Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritet Stetus Black, White, etc 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Health Care Financial Counselor 12 years 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Macneal Royston Tumbleson 19e. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jane Koel (Daughter) 22 Broadship Road Baltimore, Maryland 21222 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) 12/28/99 Middle River, Md. Holly Hill Mem. Gdns. 21. Signetura of Funarel Service Licensae 22. Nama end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 PAN. Enter the disease or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one causa on aach lina. Approximete Intarvel Between Onset end Death Immediata Cause (Final diseese or condition resulting in death) ACUTE STROKE 3 DAYS Due to (or as a consequence of) CORONARY ARTERY DISEASE 10 YEARS Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Diseesa or injury that initieted events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 1 No 1 Yes 2 2-No 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Yes 2 No

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital Physician: or Attending Ne Hospital or Attending n 24 hours after death. Ne Funeral Director: At pletely filled in by the ful

Physician

Examiner

Funeral

Director

/Medical

Directo

Funeral

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Completed

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If them 27 is marked other
any injury or other traumatic event.

Physician

Examiner

/Medical

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been signed to should be dete

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Baltimore,

completely within 2 \$ Registrar

State

DHMH 16 Rev 6/95

AYMAN, AKKAD, M. D., 31. Date filed (Month, Day, Year) DEC 2 8 1999

30. Neme end eddress of person

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of

3 Suicide

29a. Certifier

6 Could not be determined

32. Registrar's Signety

tho completed cause of death (Itam 23a) (Type, Print)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

7601 OSLER DRIVE, TOWSON, MARYLAND 21204

The Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated.

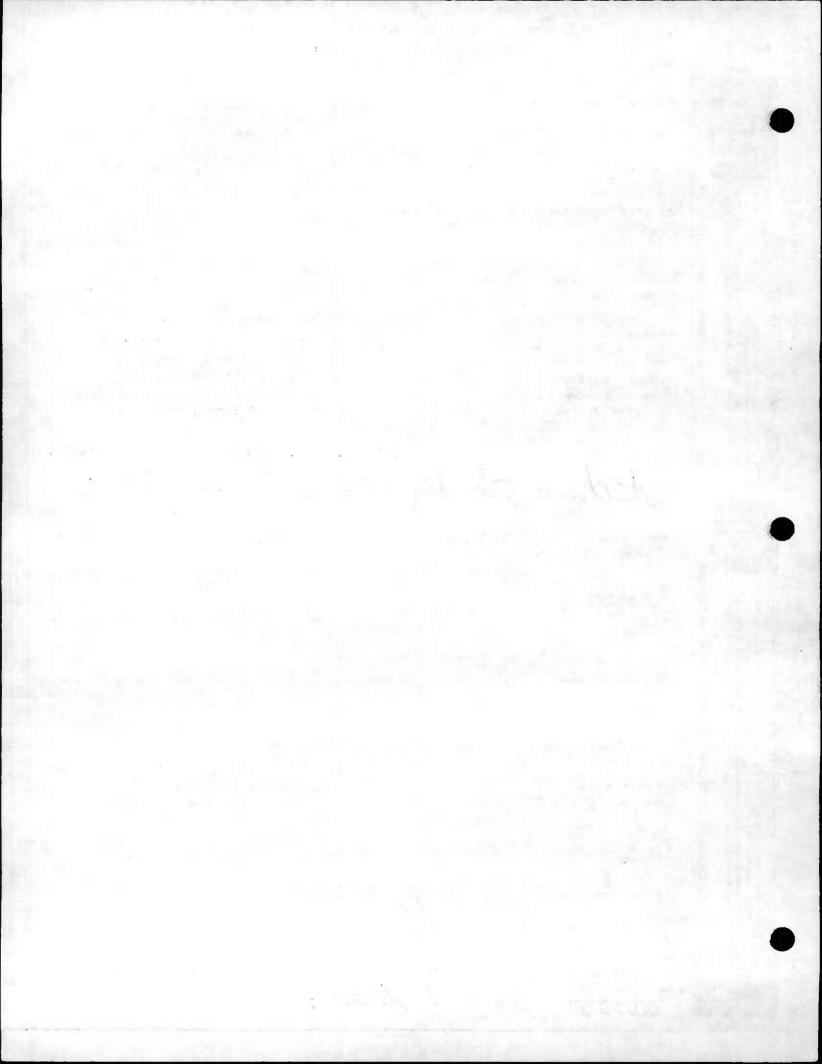
D42736

29c. License number

Location (Street end Number or Rurel Route Number, City or Town, Stata)

29d. Date signed (Month, Day, Year)

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 23, 1999 8:00 AM Darla Walsh Dec. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2514 Hermosa Avenue If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 11, 1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 KF 53 Yrs. Maryland Director 214-46-8643 Oct. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2514 Hermosa Avenue 21214 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Heelih and Mental hygiene. Important: if item 27 is marked other than "natural; or hem eny injury or other traumatic event, and Medical Essentias 1, 2026. 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e James L. Arist, Sr. Marie E. Murray 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5534 Carvel Street 20733 Mr. Donald M. Walsh / Son Churchton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 12/24/99 Towson, Maryland 21. Signature of Funeral Service Losque Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Baltimore, MD Leonard J. Ruck, Inc. 21214 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Physician Sma) Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physicien: The law requires that the death certificate be executed physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No funeral director. Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28e. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Tyes 2 No To the Hospital or Attendiwithin 24 hours efter death.
To the Funeral Diractor: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

Baitimore, Maryland 21215-0020

P.O. Box 68760.

Records.

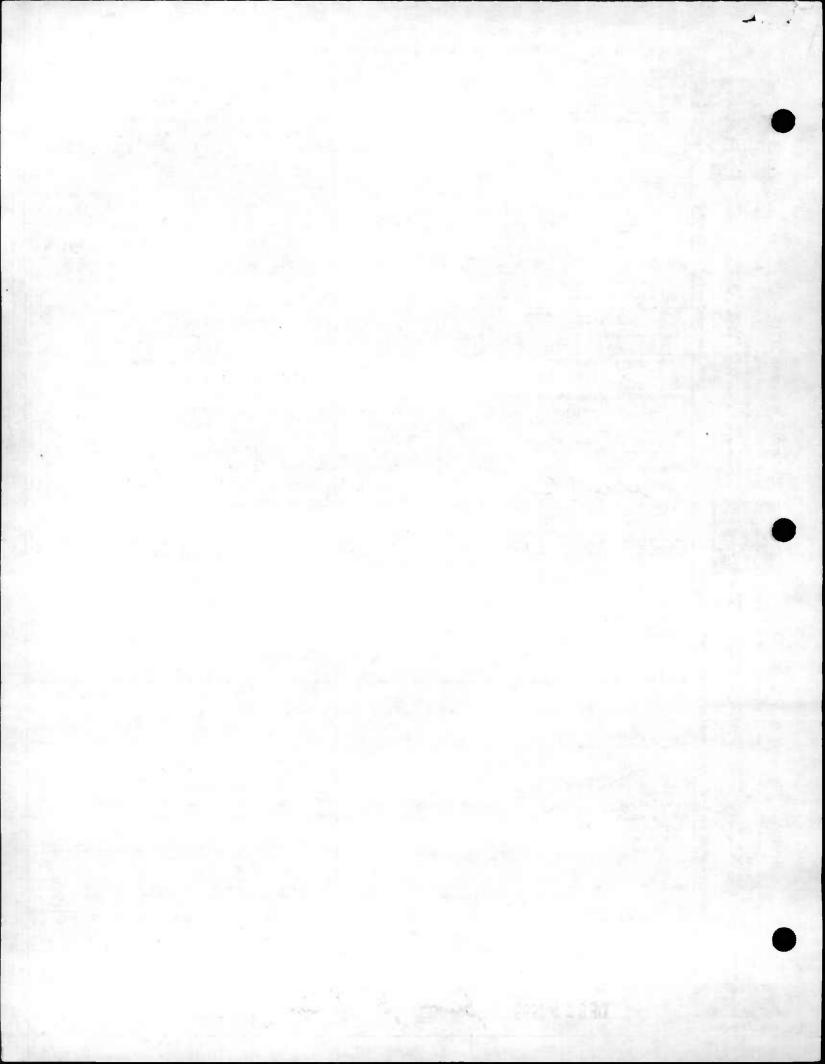
Division of Vital

DHMH 16 Rev 6/95

work 30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

32. Registrar Signature

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Yaar Month **Physician** larence 12 21:43 99 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Univ of Bultimore mo None If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Dafa of Birth (Month, Dey, Year) Birthplace (Stata or Foraign Country) **Funeral** Days 266-66-1716 100 M 2□ F 55 Yrs. **Director** Florida Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or tisma 23a or 28a-f show traumatic event, the Medical Examinat must be notified at BAHimore 1XYas 2□No Director none HARyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1005 N. USA by Funeral 1125 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No if Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter or Department of Health and Mental Hygien in Informant: If Item 27 is marked other than "natural", or then eny injury or other traumatic event. 1 Navar Marriad 2 Married 21215-0020 1 Yas 2 No Specify: Specify: AMERICAN

16b. Kind of Business/Industry 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Mg. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) Central Office 1214 Autobonn Worker Baltimore, Maryland 18. Mother's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be WILBURN Joseph UKnown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) BAHIMOR, Md ARlington St. shirley 1 burn 05 21229 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata U⊠ Burial 2 ☐ Cramation 3 ☐ Removal from State Owings Mills Maybe 4 ☐ Donation 5 ☐ Othar (Specify) tokest MRKISON 22. Nama and Addrass of Facility WANCEL 21. Signatura of Funaral Sarvice Licenses m. WACCACO FUNERAL SCRUCE 3405 Wi FRAMIN St. BANK, Chelsee Part Enter the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona ceusa on each lina. Approximata Interval Between Onset and Deeth **Physician** Immediate Causa (Final disaasa or condition rasulting in death) /Medical Myocardial Interction **Examiner** Dua to (or as a consequence of). Physician/Medical Examiner Arter. Brenucy icien and burial-trans Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence of) P.O. Box 68760. Dua to (or as a consequence of): signed by the at d be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Hypertension page 2 1 Yes 2 No 1 Yas 2 No certificate Division of Vital or Attending Physicien: 25. Was case refarred to medical axaminar?

1 Yas 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) death. edical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending invastigation 1 Netural 1 Yas 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be detarmined 3 Sulcida 28a. Ptace of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) completely filled in by 4 Homicida the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signatura and title of certif 29c. License numbe 29d. Dafa signed (Month, Dey, Year)

Registrar **DHMH 16 Rev 6/95**

State

Wade

30. Nama and addrass of person ymo complated causa of death (Item 23a) (Type, Print) ef

31. Data filad (Month, Day, Year)

DEC 29

mi

32. Registrar's Signatura

12/23/99

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 4 7 9 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of De

26.3			C	ertificate o	f Death		eg. No.	7 41	1/94
Obvenialas	1. Decedent's Name (First, Middle, L	ast)				2. Date of Deal	th Day	Year	3. Time of Death
Physician /Medical	Richard Robert White					December		1999	0325
Examiner	4a Facility Name (If not institution, g	ive street end number)			4b. City, Town, or I		4c. County	of Death	
	Fallston Genera	1 Hospita	1		Fallst	on	Har	ford	
neral		Sex 7. Ag	e (In yrs. last birtho	Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day)		9. Birthplac	a (State or Foreign
tor	022-14-7332	1 XM 2 □ F	78 Yn			May 20,			sachusett
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				10d	. Inside City Limits
ţ	Florida Dagge		Nasa Das	. D L					1 ☐ Yes 2 💢 No
Director	Florida Pasco 10e. Street and Number		New_Por	t Ritchie		1	0g. Citizen of V	What Country	?
	4228 Raccoon Lo	OD		34653	2		U.S.A		
Funeral	11. Marital Status	12. Was Decedent	Ever in U,S.		f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No-	14. Rec	e - American	
by Fur	Never Married 2 Married Widowad 4 Divorced	Armed Forces? 1 Tyes 2 1 If Yes, Give Year or Dates:	No	If Yes, specify Co		o Rican, etc.)	Specify	ek, White, etc Whi	
8	15. Decedent's E	ducation	16a. De	ecedent's Usual Occ	eupation		16b. Kind of Bu		
Completed	(Specify only highest go Elementery/Secondary (0-12)	rade completed) College (1-4or 5	(C	ive kind of work dor ie. DO NOT use reti	ne during most of wor ired)	king			
EO	Liementery/Gecondary (0-12)	2 years		sonel Mar	nagement S	pecialis	t Air	Natio	onal Guard
Be C	17. Fether's Neme (First, Middle, Las	1)				ne (First, Middle, I			
0	William H. Whi	te			Mary J	ane Woo	ds		
	19a. Informant's Name/Relationship	(Type, Print)	19b. N	aiting Address (Stre	et and Number or Ru			State, Zip Co	ode)
	Barbara Tedesco	/ Sister	54	4 Sandpir	er Cir.	Delray B	each F	L 334	445
	20a. Method of Disposition		20b Place of D	sposition (Name of crematory or other p	T		20c. Location -		, Stete
	1 ☐ Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec			sh Cremat		/20/1999	Laur	el MI)
	21. Signature of Funeral Service Lice		Daito/ Wa	22. Name and Add	Iress of Facility		паці	CI III	
) W	1 BO 16	2		C. Miller			MD (1100
	23a, Part1, Enter the disease, or con	notications that caused	the death. Do not		Belair Ro		timore		21206 pproximate
	23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each lin	10.					i In	nset and Death
	Immediate Cause (Final	0	,						
	disease or condition resulting in death)	· Preum	Punto (or an annu	reasurance of .				iu	nknowne
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Examiner	Sequentially list conditions	V	Dua to (or as a cor						
EX	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury		(or as a cor	ougueriou orj.					
Ca	that initiated events	C	Due to (or as a con	sequence off:				1	
Medical	resulting in death) Last			organisa org.					
2		d							
Physician/	Part II. Other significant conditions	contributing to death hi	ut not resulting in th	e underlying cause	given in Part I	23b. Did to	bacco use co	ntribute to th	ne cause of death?
hys		The state of the s		- maniful cause			es 2 No	3 Probal	1
by P									
Pa						24a. Wes a		24b. Were	autopsy findings
Completed						perion	/		eletion of cause
EO						1 D Y	es 2 No		res 2□ No
	25. Was case referred to medical				OC Dines of De-			101	23 ZU 140
o ne	exeminer?	Hospitel:	nt 2□ER/Outpa	tiont all post	Where	oth <i>(Check only on</i> dome 5 ☐ Reside		or (Conside)	
2	27. Mannar of Death			tient 3L DOA	4 □ Nursing H	28d. Describe h			
tlor	1 ☑Neturel 5 ☐ Pending	28a. Date of Inju- (Month, Da)	Year) Inju	ry W	ork? □ Yes 2 □ No		,_,, _,,		
Certification:	3 Suicida 6 Could not I	De Diana - (Iniv	ury - At home, farm			28f. Location /S	treet and Numb	per or Rural F	Route Number.
E	4 Homicide determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
2	29e. Certifier 12 Certifying P	hysician: To the best of	of my knowledge d	eath occurred at the	time, date and place	, and due to the o	ause(s) and ma	onner es stat	ed.
edical		miner: On the besis of and manner sta	examinetion and/o	r investigation, in m	y opinion, deeth occu	rred at the time, d	ate and plece,	and due to th	ne cause(s)
Z e	29b. Signature and title of certifier			29c. Lice	nse number	2	9d. Data signe	d (Month, Da	y, Year)
	A			DR	7612		12/19/	á.	
	20 Name and address of a second	namalas de la	and there are the				, (7	
	30. Neme end address of person who				al Air n	Daruland	2101	4	
	Mohamad Alabr 31. Date filed (Month, Day, Year)	39 Panietre	1 Hgora 1 ars Signature	TIVE D	el Air n	ia ylana	2101	7	
tate	o. Date med (month, Day, redr)	SZ. Megistra	n'a ciduatora	1. 15 11					

Registrar

DHMH 16 Rev 6/95

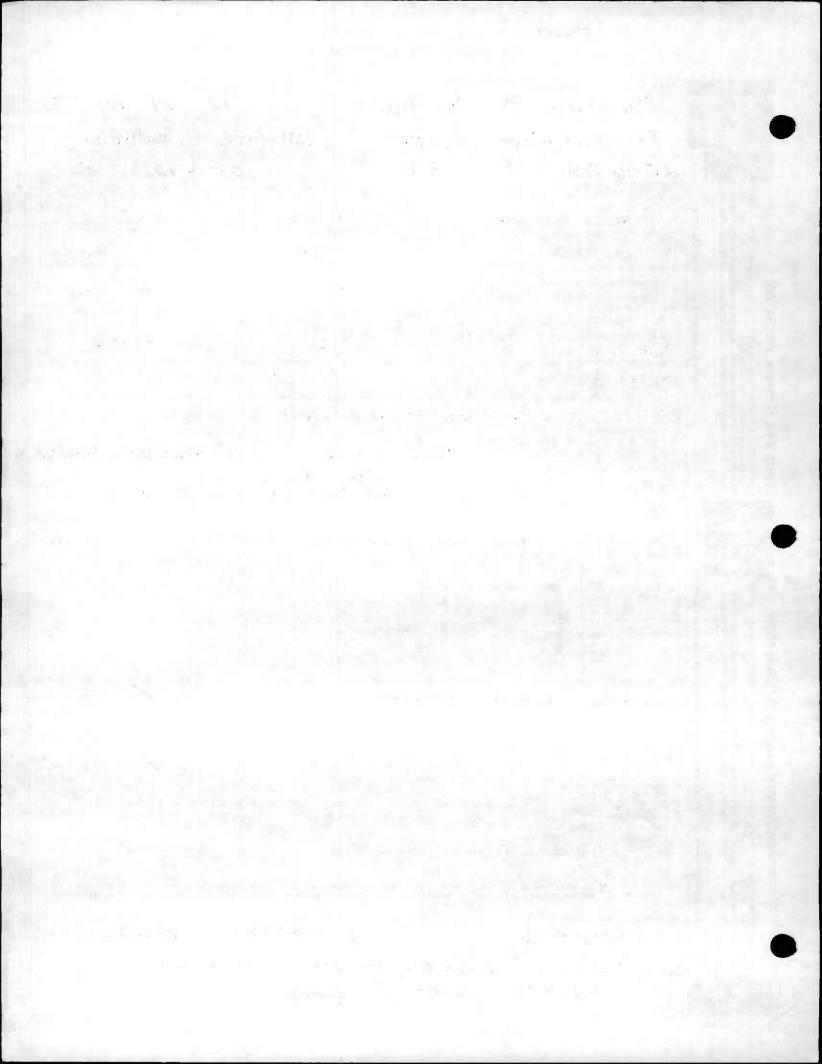
State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** comans 24 1999 1 d 0830 AM nristine /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor

9. Birthplace (State or Foreign
Country) Baltimore GENESIS
7. Age (In yrs. last birthday) tranklin Woods | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | 8. Date of Birth | Month, Dey, | 0.3 - 1.8 5. Social Security Number 6. Sex **Funeral** Year) 1 M 2 F 87Yrs. 217-16-793 Director Georgia Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, me Medical Examiner must be notified at page. 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 29C Mopec Circle 21236 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: g 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Julia Webb David Dodson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy J. Hetterich (Daughter) 3746 Elmora Avenue, Baltimore, Maryland 21213 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith 12/28/99 Baltimore, Maryland 22. Name and Address of Fecility
Schimunek Funeral Home Inc. 21. Signature of Funeral Servica Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Fibrosi s /Medical Immediate Cause (Final Pulmonara 3 4x . I diopatric disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): requires that the death certificate be exec Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Posilure 1 Yes 2 No 3 Probably 4 Unknown Rencal chronic þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury et Work? 27. Menner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how Injury occurred Certification: after death. Director: After ti 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ne Hospital or Atte n 24 hours after de ne Funeral Directo bletely filled in by the 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner as steled.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated. To the Hosp within 24 hos To the Fune completely fi Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number S. Rogues D 0053720 12 20 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) allston, MD 21047 ~ alla, Belair 31. Date filed (Month, DE Ca2 9 1999 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40796 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dec. 24, 1999 11:55 PM Emil Fidele Zemarel /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Timonium Stella Maris Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 3, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 113 M 2□ F Yrs. 82 Director 159-16-3047 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits I be filed within 72 hours after death with the May/ar nital Hygians. ed other than "netural", or frams 23s or 23s-f show e event, the Madical Examiner must be notified at 1 ☐ Yes 2 € No Director Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Rd. 21093 U.S.A. Funara 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: WWII Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 3 DtWidowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician Entertainment parmit. Pegas 1 and 2 should be file Department of Heelth and Mental Hy important: if them 27 is marked other eny Injury or other traumatic event BOSB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Patrick Charles Zemarel Lucy Gatto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John A. Zemarel/Son Lutherville, Md. 21093 3 Hickory Knoll Ct. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grd. 12/28/99 Timonium, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease shock, or heart feiture. cutions that raused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, no cause of each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Heart Failure /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physicien end for use as the buriel-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of) P.O. I Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? s been signed by to should be detach Renal Failure Chronic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Kinknown Records, by 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Complated Diabibi mellitus 24a. Wes en eutopsy performed? e certificate has I 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funerei Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Cartification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43725

State Registrar

DHMH 16 Rev 6/95

DEC 2 9 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signature & Sparks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOUN 201-109

Back River Neck Rd Ballimore MD 2121

Piease Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth December **Physician** 10:21 AM Daniel Weslev Anacki 12, 1999 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Sociel Security Number 020–20–9477 If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Mar 22, 19 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) **Funeral** Months Deys 12 M 2 □ F 70 Yrs. Director 1929 Massachusetts Usuel Residence of Decedent 10a, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 1019 Placid Court 21012 USA 234 Funerai 12. Wes Decedent Ever in U.S. Armed Forces? 1 (BYes 2 □ No 1954— If Yas, Give Year or Detes: 1956 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Meritel Status parm. Peges 1 and 2 should be filed within 72 hours effer of Department of Heelin and Mental Hydines. Important: If fem 27 is marked other than "natural", or the my injury or other traumatic event, me Medical Executarity 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grede completed) Boiler Elementary/Secondery (0-12) College (1-4or 5+) Manufacturer Engineer 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Annie Coban Paul Anacki 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Eloise Anacki / wife 1019 Placid Court, Arnold, MD 21012 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dec 15 1 Buriel 2 Cremetion 3 Removel from 4 Donation 5 Other (Specify) Crownsville, MD 1999 MD Veterans Cemetery 21 Signature of Fuperal Service Lice 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Enter the diseas or heart failure. Approximata Interval Betw Onset and D List only not enter the mode of dying, such es cardiac or respiretory arrest, Physician Immediate Ceuse (Finel disease or condition realing in death) /Medical Examine Physician/Medicai Examin attending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury P.O. Box 68760, thet initieted avants resulting in death) Last Due to (or as e consequence of): Pert It. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records. Be Completed by 24b. Wera autopsy findings evailable prior to completion of cause of death? funeral director, page 2 should 24a. Wes en eutopsy performed? certificate 1 Yes or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending invastigation 1 Yes 2 No 24 hours after deeth. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier ritifying Physician: To the best of my knowledga, deeth occurred et the time, date end place, end due to the cause(s) and mannar as stated. completely 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and many stated. To the within 2 29c. License number 29d. Date signed [Month, Day, Year]

State Registrar 31. Dete filed (Month, Dey, Year)

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eted cause of deeth (Item 23a) (Type, Print)

OEC 1 2 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth BENJAMIN BRAVERMAN 12

Physician /Medical Examiner **Funeral**

Director

Director

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiane. Important If hem 27 is marked other than "naturel", or frems 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at

Funeral Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify. à 3√ Widowed 4 Divorced W II Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Fabrication 17. Father's Neme (First, Middle, Last) Be Abraham Braverman 2 19a. intorment's Name/Raiationship (Type, Print) Jules Braverman/ Brother 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e, Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Crematory J Servica Licensee 22. Name end Address of Fecility **Physician** /Medical Immediate Ceuse (Final disease or condition rasulting in daath) DIABETES Examiner Due to (or es e consequenca of) Physician/Medical Examiner The law requires that the death certificate be axecuted bunal-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseese or injury thet initiated evants rasulting in daeth) Last end Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, attanding physician for use es the buna Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the undarlying cause given in Pert I. DEMENTIA þ cate has been significant category. Completed this certificate al or Attending Physician: The saftar death.

I Director: After this certificated in by the funeral director, pa Be 25. Was case reterred to medical 28. Piece of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yas 2 No 28a. Dete of injury (Month, Day Year) 28c. injury at Work? 27. Manner of Deeth 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 3 Suicide Plece of Injury - At home, term, street, fectory, office building, atc. (Specify) 4 Homicida e Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, deta end plece, end due to the causa(s) end menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) and menner stated. edicai 29a. Certifier (Check only one) To the vithin 2 29c. License number 29b. Signeture end title of certifier

01.30 4b. City, Town, or Location of Deeth 4e Fecility Nema (If not institution, give street end number) 4c. County of Death Mariner Health-Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Deys 1 M 2□ F Months Hours Yrs 87 220-09-0314 March 16, 1912 Maryland Usuel Residence of Decedent 10d. inside City Limits 10a. Steta 10b. County 10c. City, Town or Location 1 ☑ Yes 2 ☐ No Maryland Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 4825 Mel.bourne Road 21229 TISA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Meritel Status Black, White, etc. 1 M Yes 2 □ No If Yas, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Specify: White 16b. Kind of Business/Industry Construction 18. Mother's Neme (First, Middle, Maiden Surneme) Dora Tretrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) 11 Slade Ave. Apt. 603 Baltimore, MD 21208 20c. Location - City or Town, Stete 12-13-99 Brentwood, Maryland John M. Taylor Funeral Home. Inc. 147 Duke of Gloucester Street Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart feilure. List only one ceuse on each line. Approximete intervel Batwean Onset end Death 10 YEARS

> 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

3. Time of Death

24b. Wera autopsy findings eveilable prior to completion of cause ot deeth? 24a. Wes an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

52360

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed causa of death (Itam 23e) (Type, Print) RD. SUI TRZE 300 MID

State Registrar 31. Dete filed (Month, Dey, Year)

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32. Registrer's Signeture

050 1 6 1949

P 31

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** atober Marie Agnes Bowers 0617 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Hunder 24 Hrs. 8. Dete Washington 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) October 22,1919 6. Sex Birthplaca (State or Foreign Country) **Funeral** Months 1□ M 25 F Deys 577-18-2356 Yrs Director 79 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19112 Longmeadow Road 21742 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No It Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: À 3X Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mentel Hygies Important: If item 27 is marked other th any fulury or other traumatic avant, thy pages. 11 Realtor Real Estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Harry W. McCormick Rose Leona Johnson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Cathy O'Bryan/Daughter 9130 Balcones Club Dr. Austin, TX 78750 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method ot Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removal trom State 4 ☐ Donetion 5 ☐ Other (Specify) 10/25/99 Hancock, MD St. Peter's Catholic 21. Signeture of Fundral Se 22. Name end Address of Fecility Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical a Terminal Ventricular Examiner Physician/Medical Examiner Lon of Myocardial Due to (or as a consequence of): ettending physician and for use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last myocardial Due to (or es consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ cate has been sig. 24b. Were eutopsy tindings available prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, term, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director.

certificate

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el Hygiene.

Baltimore, Maryland 21215-0020

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DEC 2 9 1999 Registrar

29a. Certifier (Check only one)

29b. Signeture and title of certifier

31. Dete tiled (Month, Day, Year)

32. Registrer's Signeture

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Vapuchis

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1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29c. License number

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29d. Date signed (Month, Day, Year)

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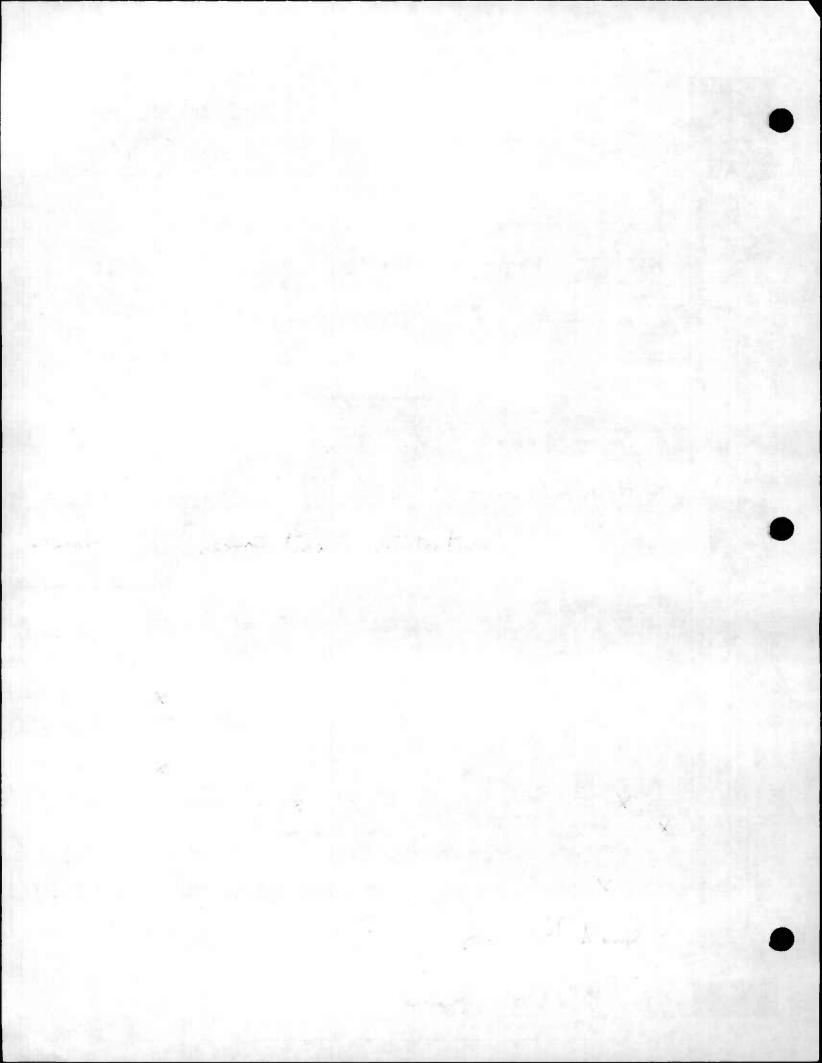
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ysician Medical	1. Decedent's Name (First, Middle, L Dorothy	Marie		Bowyer		2. Dete of De Month Decemb	Day	.999	3. Time of Deet 6:00 pm
aminer				1-1-1	4b. City, Town, or L		th 4c. County	of Deeth	
	Frederick Health 5. Social Security Number 6.		rs. last birthday)	If Under 1 Yeer	Frederic	k 8. Dete of Bi	Fred		
eral ctor	216-24-5753 Usuel Residence of Decedent	1 M 2 X F	69 Yrs.	Months Deys	Hours Min.	Feb 4	ey, Year)	Cour	plece (Stete or Fo htty) 1and
4	10a. Stete 10b. County		City, Town or Lo	cation				1	0d. Inside City Li
ctor	Maryland Freder	rick	Freder	rick					1 X Yes 2
rai Director	10e. Street and Number 444 West South	Street		10f. Zip Code 21	701		10g. Citizen of V U.S		ntry?
by Fune	3 ₩idowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No It Yes, Give Yeer or Detes:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bled	e - Americ k, White, Whi	
rt, pre Madrail	15. Decedent's E (Specify only highest gi		16e. Deced	dent's Usuet Occup	pation during most of work d)	king	16b. Kind of Bu	siness/Ind	dustry
mpi	Elementery/Secondery (0-12)	College (1-4or 5+)		DO NOT use retire	d)		Own 1	Home	
Be ve	17. Fetner's Neme (First, Middle, Las	A	Tracy		18. Mother's Nem	ne (First, Middle	, Maiden Sumem		ri
To To						10			
2	19e. Informent's Name/Reletionship Lisa R. Bowyer/Da				Street, E				
retto	20e. Method of Disposition		Plece of Dispo	sition (Neme of	1	Dete	20c. Location -		
any injury or pnce.	15 Burial 2 □ Cremetion 3 [4 □ Donetion 5 □ Other (Special	ify) Mt	Olivet		y Dec 15,	, 1999	Freder	ick,	Marylar
any la	21. Signature of Funeret Service Lice	nsee	22	R. Name end Addre Keeney	& Basford	l P.A. 1	Funeral 1	Home	
	Keethym Ke	ben 1100	706 10	6 East C	hurch St.	Freder	rick, Ma		nd 21701
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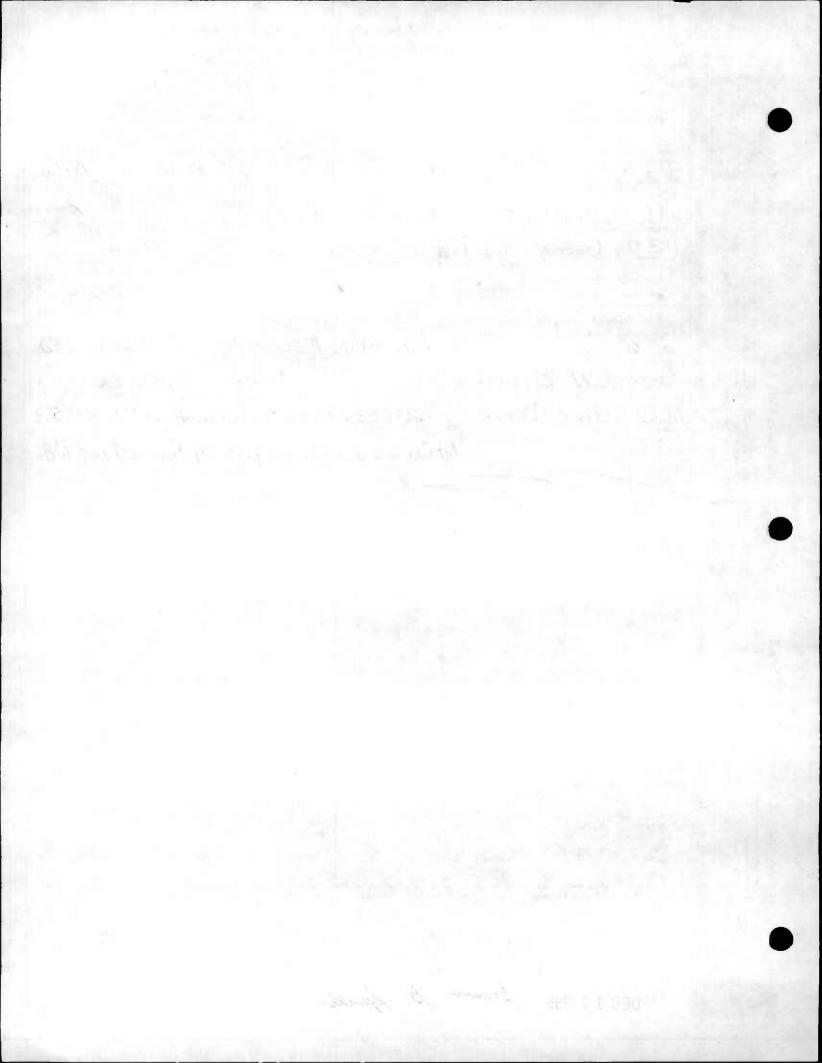
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Yea **Physician** James Ivory December 8, 1999
sation of Death 4c. County of Deeth Boomer /Medical 12:30 PM 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, MD If Under 24 Hrs. 8. Date of Wiconico 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5-23-/3 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 1MM 20 F 86 Yrs. N.C. 212-16-188 Director Usual Residence of Decedent 10a. State 10b. County Show 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director DOMERSET RINCESS 'natural', or items 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2185 USA JREENWOOD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Raca - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify à Black 3 Widowed 4 ☐ Divorced Year or Detes: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) SELF-EMPLOYED Automobile ECHANIC 6 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any Injury or other traumatic event 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be GEORGE DOOMER DORA SPENCER 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PRINCESSANNE, MJ. 21853
Date 20c. Location - City or Town, State 32686 Ed BOSTON RO hRISTINE 20b. Pleca of Disposition (Name of cometery, cremetory or other plece)
Mt.Carmel Church Cemetary 20a. Method of Disposition 1. Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenser 22. Name end Address of Fecility 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Several Examiner CAndrouss who Desense Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last burial-tran Due to (or es e consequence of): P.O. Box 68760 the Due to (or es a consequence of) ò Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy 22 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

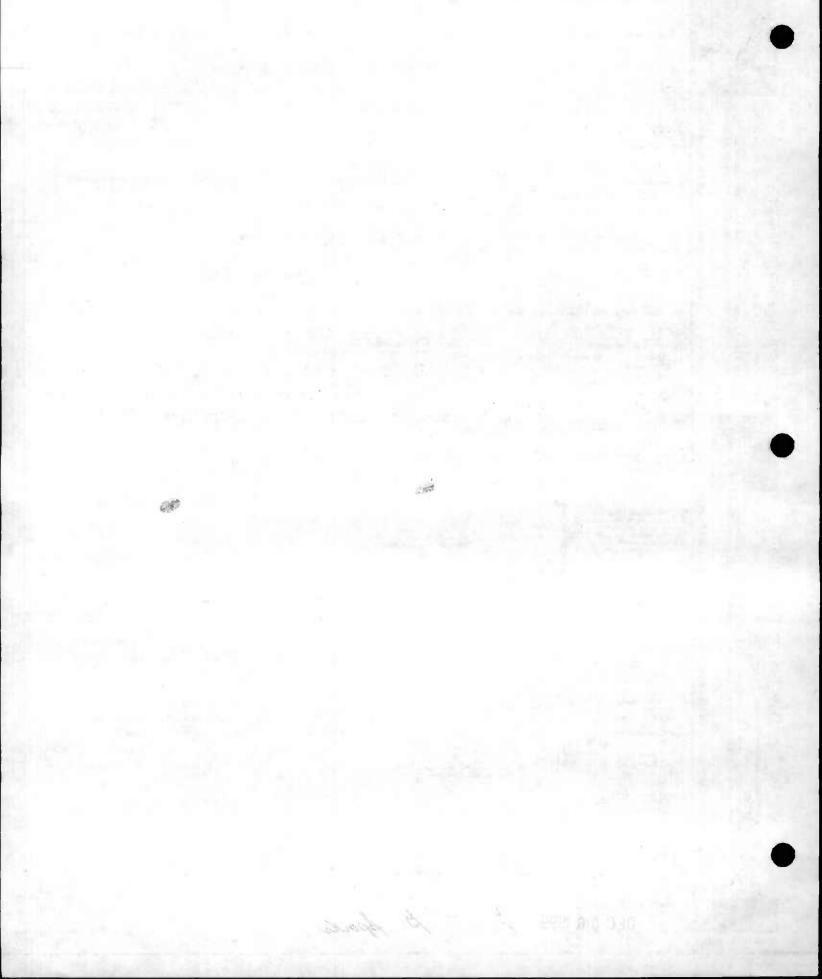
To the Funeral Director: After this certifica complately filled in by the funeral director; p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, streef, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Medical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MATKINS 4011 31. Date tited (Month, Dey, Year) State DEC 1 0 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month Bera **Physician** Dan DECEMBER 03 1999 11:31PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1₩ M 2□ F Months Yrs. 237-32-4379 75 Director January 26,1924 Pennsylvania Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. tnside City Limits 1 ☑ Yes 2 ☐ No Director Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34666 Railroad Ave. 21850 IISA 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yas, Give Yaar or Datas: WW T Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. 11. Maritat Status fled within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Navy Baltimore, Maryland 21215-0020 'natural', or 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorced White WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Minister Religion parmit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumeme) Stanley D. Berg Myrtle Burgess 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Berg Jr./Son 3200 W. County Rd., Lizton, IN 46149 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) 12/7/99 Pittsville Cemetery Pittsville, MD 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Holloway Funeral Home Professional Association 1eme 501 Snow Hill Rd., Salisbury, MD21804 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximate tritarval Between Onset and Death Physician tmmediata Causa (Final disease or condition resulting in death) /Medical carcinong UN KNOWN Examiner Physician/Medical Examiner The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician is the buriel P.O. Box 68760, Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 2 24b. Were autopsy findings evailable prior to completion of cause of daath? Completed 24a. Was an eutopsy performed? page 2 2 No certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was casa refarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 Hnpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Afteri 1 Netural 5 Pending investigation Hospital or Attanding 24 hours after death.
 Funeral Director: After 19 per 19 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, data and place, and due to tha cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) \$ 29b. Signature and titla of certifie 29d. Dete signed (Month, Day, Year) intern Medica 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Docter's Louise, John's Hoplans Hospita 10+1VA Touler JON 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar DEC 0 6 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EDNA M. CAWTHORNE DEC. 13 1999 12:30 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 LINCOLN PARKWAY ANNE ARUNDEL If Under 1 Year 8. Date of Birth (Month, Day, Year) DEC 13 19 9. Birthplace (State or Foreign Country) MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Davs Hours Months 1 M 20 F Yrs Director 213-22-1700 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural', or Herns 23s or Funeral 29 LINCOLN PARKWAY 21401 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is merked other any Injury or other traumatic event. along 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES GRANDISON ANNIE KIMBLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20866 19a. Informant's Name/Relationship (Type, Print) CARL CAWTHORNE (SON) 4201 LEATHERWOOD TERRACE BURTONSVILLE, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/20/99 CROWNSVILLE, MD, MARYLAND VETERAN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21101

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate interval Between Onset and Death **Physician** Arrhythuria Immediate Cause (Final disease or condition resulting in death) /Medical 4 minutes Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) for use as P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to been si Completed 24a. Was an autopsy performed? completion of cause of death? s certificate has t 2 K No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the function. 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) estgate Rd. Annapolis Md 21401 selonich, mio. E. 31. Date filed (Month. 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95**

State

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Margaret P. Cox 15, 1999 December 8:30 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 10,1921 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 10 M 20 F Days 78 Yrs. 215-18-0355 Dèc. Director Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits YXYas 2 No permit. Peges 1 and 2 should be filed within 72 hours after death with the Mi Department of Heelth end Mentel Pyglene. Important: if item 27 is marked other than "natural, or items 23s or 25s Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 849 Singing Hills Court 21401 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Datas: Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: p 3 DaWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Private Companies 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 8 Bertha Boyden Henry Lewis Priset 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Terry C. Cox/ Son 6389 McKendree Road Dunkirk, Maryland 20754 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12-20-99 Crownsville, MD George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onsat and Daath **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Due to (er es e conseduence of): ettending physicien end if for use es the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detech 3 Probably 4 Unknown 1 Yes 2 No 1100 þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? 1 Yas 20 No 20 NO 1 Yas certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours effectors. After this certificator the Funeral Director; After this certificator physicial director; It 25. Was case referred to medical 8 26. Place of Death (Check only ona) Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes VINO edical Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? T Natural 5 Pending 1 Yas 2 No 2 ☐ Accident investigation 6 ☐ Could not be 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of contiller 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) ran P. C ed (Month, Day, Year) 32. Registrar's Signatura State

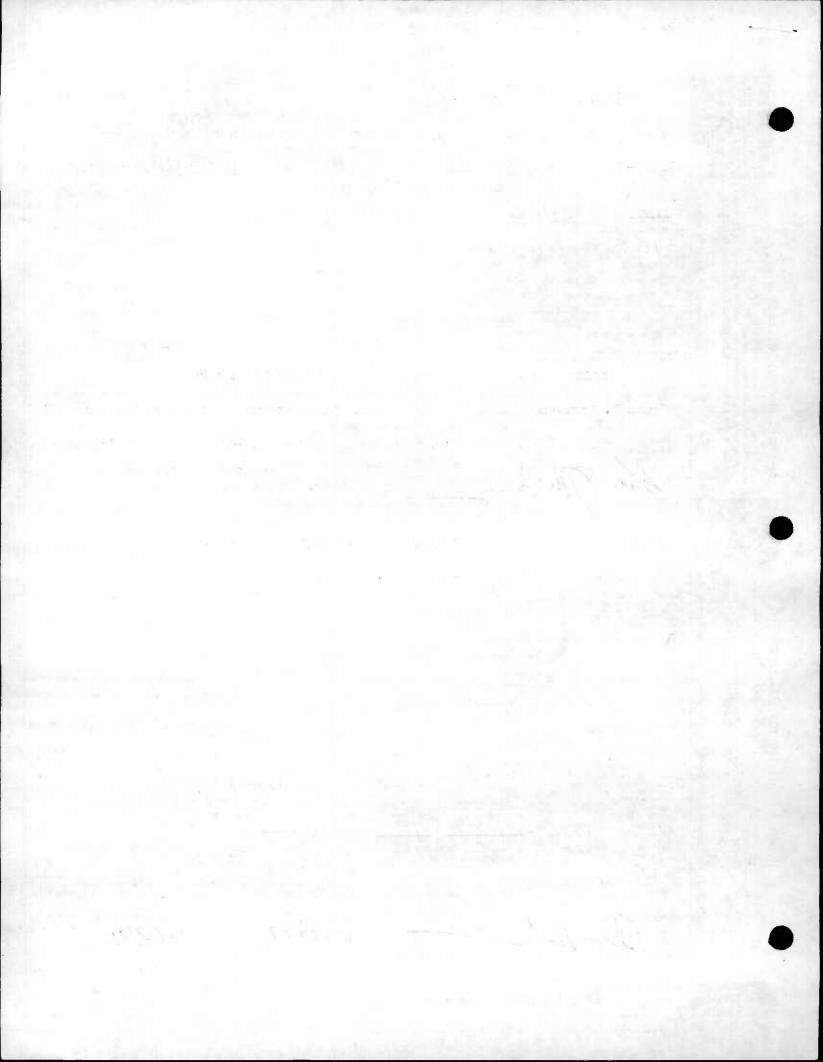
Registrar

DEC 1 7 1999

Please Type or Print in Biack indelibie ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended items#1,10a,28a-c, 12/20/99 Certificate of Death FCHD,KS Decedent's Name (First, Middle, Last)
 ADAMS 2 Date of Death **Physician** 3:10PH Maureen (ar Son 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner HOSPITAL Baltimore BALTIHORE OF MARYLAND 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 6. Sex **Funeral** Months Days 1 M 200F Hours Yrs. Director 578-72-5250 55 44Northern Ireland Usual Residence of Decedent 10d. fnside City Limits 10a. State 10b Counts 10c. City. Town or Location 1 Yes 2 No 28a-f Directo 10e. Street and Number 10g. Citizen of What Country? 8 05 102 chase 20164 238 COUYT Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
ff Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) natural, or flams 14. Race - American Indian, 11. Meritef Stetus Black, Whita, atc 72 hours after 1 Never Married 2 Married 1 Yas 200 No Baltimore, Maryland 21215-0020 Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filled within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental marked William Adams Annie McKibbon permit. Pages 1 and 2 at Department of Health and Important: if Item 27 is m any Injury or other 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Carlson 102 Seneca Chase Court Sterling, Virginia 20164 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Mathod of Disposition Data 20b. Place of Disposition (Variety of Commercial Commer WBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Loudoun Funeral Chapel Min Leesburg, Virginia 20177-1316 riper 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical negative Examiner Physician/Medical Examiner requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of and Records, P.O. Box 68760 Due to (or as a consequence of) use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by fallure P 2 24b. Wara autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? NIA 2 10 No cartificate 1 Yes 1 Yes 2 No Division of Vital al or Attending Physician: T s after death. Il Director: After this cartificat od in by the funeral director, p 25. Was case raferred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 14 HOPM 2 Accidant 3: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida a Funeral Di Petaly filled in 29a. Certifiar 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 12/7/99 D52477 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Baltimore, MD 21201 Aaron Rappaport, M.D. 32. Registrars Signature State 1 0 1999

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2204 Idelen 1999 Desember /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner of Manland Baltrione City Baltimore City riversity Medizal If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, July 3, 1944 Birthplace (Stete or Foreign Country) 6. Sex **Funeral** Months Days 10 M 20 F Yrs. Director 216-42-5933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumstic event, the Med cal Exercise must be notified at 1 ☐ Yes 2√☐ No Director Maryland Anne Arundel Annapolis 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 Colonial Park Manor Annapolis 21401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effert Department of Health and Mental hygiene. Important: If tem 27 is marked other than "natural", or ther eny Injury or other traumatic event, the Medical Enterin Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: P 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 Rudolph Nash Eva Mueller 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Herbert Canter/ Husband 43 Colonial Park Manor Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 12-17-99 Annapolis, Maryland 21. Signature of Funeral Service Lis 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner :4:2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown :rrho3;5 p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Be 27

signed by the attending physician and id be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, this certificate has To the Hospital or Attending Physician: within 24 hours ster death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Medical Certification: To

Baitimore, Maryland 21215-0020

			12.100 2,2.110		
5. Was case referred to medical		26. Place of D	eeth (Check only one)		
exeminer?	Hospital:	Home 5 ☐ Residence 6 ☐ Other (Specify)			
7. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how injury occurred		
3 Suicide 6 Could not be determined		street, factory, office	28f. Location (Street end Number or Rural Route Numb City or Town, State)		

29a, Certifier (Check only one) 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number 29d. Date signed (Month, Day, Year) Deember 13, 1999 13412

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)

22 5.6 31. Date filed (Month, Day, Year)

State Registrar

1 6 1999

32. Registrar's Signeture

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 40807

			C	ertificate of	of Death		Reg. No.		
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Physician /Medical	CHARLES ARTHUR	COOK				DEC.	11 1	999	1:00 PM
Examiner	4e Fecility Neme (If not institution, g TALBOT HOSPICE				4b. City, Town, EASTOI	or Location of Deat	4c. County		
uneral rector	5. Sociel Security Number 6. 217-36-2193	Sex 1 M 2 □ F	ga (In yrs. lest birthd 71 Yrs	Months D		Hrs. 8. Date of Bir Min. (Month, De JUNE 8,	y, Yeer)	9. Birthp Cour MARY	piece (Steta or Foreign htty) LAND
3 - 277	Usuel Residence of Decedent 10e. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
items 23a or 28a-f show instrument be notified at Tuneral Director	MD TALBOT		CORDOV						1 Yas 2 No
Dire	10e. Street end Number			10f. Zip Co	de		10g. Citizen of	Whet Cour	ntry?
Ta E	30410 CHAPEL STA			2162			U.S.A		
by F	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 H Yes, Give Yaer or Dates:		3. Wes Decedent If Yes, specify (1 ☐ Yes 2 🔀		? (Specify Yes or No uerto Rican, etc.)	Specif	ce - Amaric ck, White, y: WH]	etc.
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Be Completed	(Specify only highest g Elemantary/Secondary (0-12) 7	College (1-4or	5+) 'life	ive kind of work do e. DO NOT use re FARMER	one during most of etired)	working	AGRICU	JLTURI	3
o Be	17. Father's Neme (First, Middle, Las ARTHUR COOK	51)			18. Mother's	Name (First, Middle,	311	na)	
F	19a. Informent's Neme/Relationship	(Type, Print)	19b. M	eiling Address (St		r Rurel Route Numb		, Stete, Zip	Code)
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	20e. Method of Disposition		20b. Plece of Di	sposition (Nama o	of	Dete	20c. Location		
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ıl	Immediate Cause (Final disease or condition	1/2	17 Na	una	11	onea	sa	4	Lucus
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by Physician	Total Sules significant conditions	contributing to death t	of not resulting in th	e underlying caus	e gwen ar r en i.		Yes 2 No	3 □ Pro	
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Certif	4 ☐ Homicide determine	d 28a. Place of in	jury - At home, farm, c. (Specify)	street, factory, of	fice	City or To	street end Num wn, Stete)	per or Hun	al Route Number,
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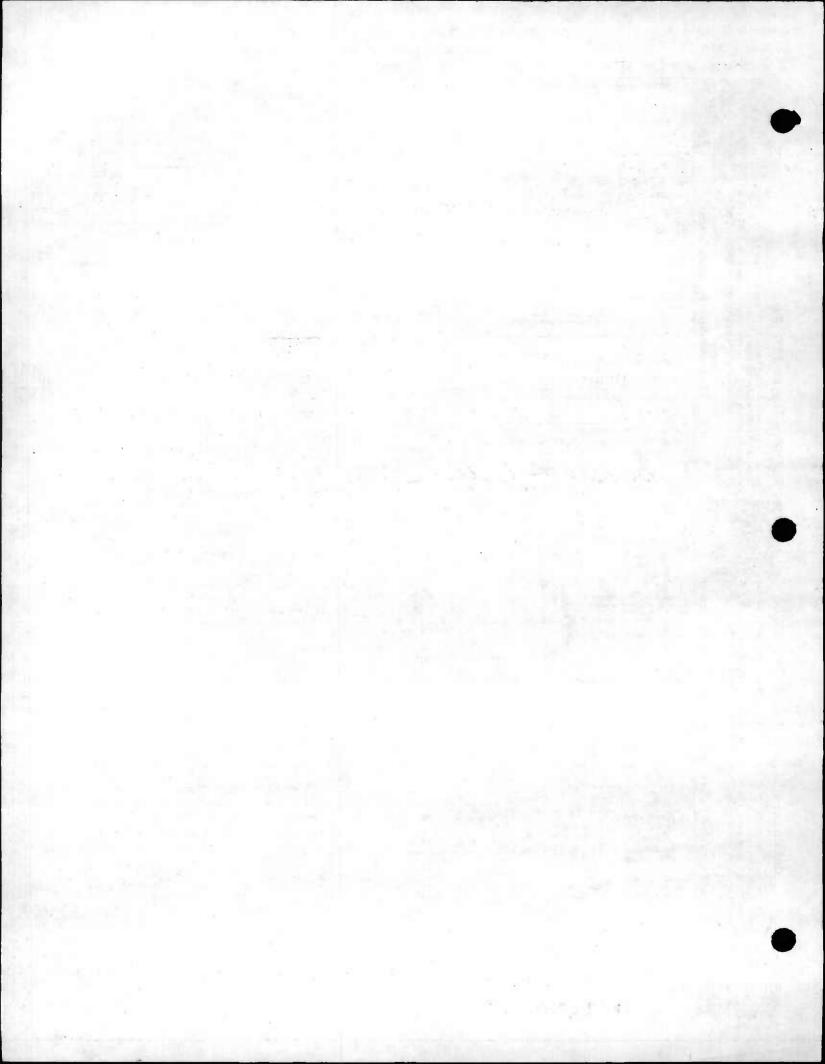
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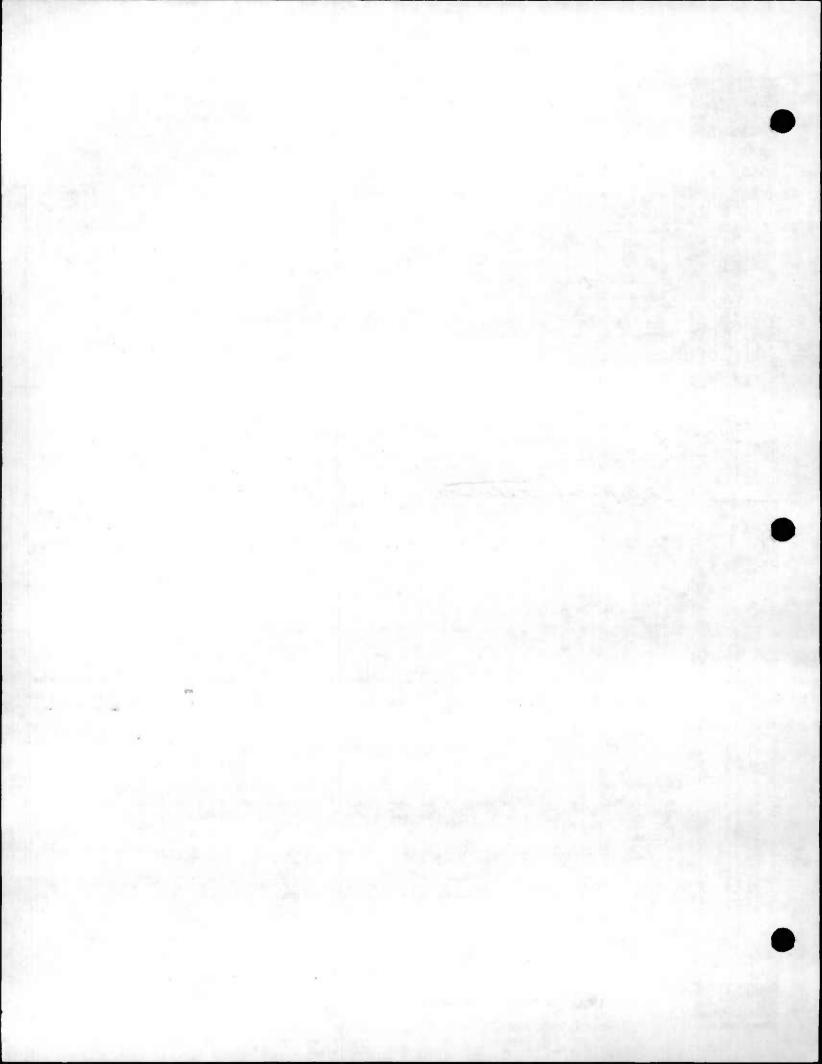
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Baitimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours eiter death with the Meryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-4 show ency holyry or other treumstic event, the Wediel Escripter must be notified at ance. To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Year or Detes:	Ever in U,S. 13 PNo	8. Was Decedent of I if Yes, specify Cub		Specify Yes or No- to Rican, atc.)	14. Race - An Bleck, Wh Specify:	nerican Indien, nite, etc. White
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Bait pemit. Departr Importu	Barbara A. W 23a. Part1. Enter the disease, or coshock, or heart failure. List or	illiams, Ow	mer 1	100 Peters	sville Ro	uneral Ho ad, Bruns	wick, MD	21716
Service by Service by Physician and Physician Examiner Service burief-transit	fmmediata Causa (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events	a. Multig.	Due to (or es a cons	equenca of):				
Seeth certific strending of d for use as	Pert II. Other significant conditions	d	Due to (or es a conse		ven in Part f.	23b. Dfd toba	acco use contribu	ite to the cause of death?
P.O. delegates d						1 ☐ Yee	2010 3 I	Probably 4 Unknown
D 2 2 0						24a. Wes an performe		b. Were autopsy findings available prior to completion of cause of daath?
= F # 8 8						1/5-Yas	2□ No	1 LYes 2□ No
VITALI Idelen: The Certificate rector, per	25. Was case referred to medical examiner?					ath (Check only ona)		
Of VITA Phyalclen: rithis certific ral director,	1 XYes 2 No	Hospitat: 1 Inpati	ent 2 ☐ ER/Outpati	BIT 3LI DOA		dome 5 ☐ Residen	ca 6 Dother (S)	oecify) Scene
DIVISION OF or Attending Physical death. Director: After this din by the funeral of ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Data of Inju (Month, Da tion 12-14-9	Found	Wo	ryat rk? Yes 2. ☑No	motoruch		dent
DIVISION OF To the Hospital or Attending Phy within Ext hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could no determine	28e. Piece of In	jury - At home, farm, s ic. (Specify)	streef, fectory, office		City or Town,	Stote) Rt - 3	Rurel Route Number,
To the Hospital within 24 hours To the Funeral I completely filled	29a. Certifier 1 Certifying (Check only one)	Physician: To the best taminer: On the basis of	of my knowledge, das f examination end/or	ath occurred af the ti	me, date and pleca opinion, deeth occu	Frederica, end due to tha cau	sa(s) end mannar	as stated. ua to the causa(s)
Med Med	29b. Signature and title of certifier	end mannar st	eted.	29c. Licens	se number	290	I. Date signed (Mo	nth. Dev. Year)
F 3 F 8	> Dennis	2. Chuta	0		C.M.E.			15, 1999
	Dennis J.	Chute MD	death (ftem 23a) (Type		Street,	Baltimore,		
State Registrar	31. Date filed (Month, Day, Year) DEC 2 07		rar's Signature	4	de			
		The Same	No.	-				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		eg. No.	40809							
Physicia	GCOLSE MILION CITIES	2. Data of Dear Month Decembe	Day '	3. Time of Death 999 11:50 PM							
/Medica L Examine	Ab Chi Taur of L		4c. County of								
	Frederick Memorial Hospital Frederic			derick							
Funeral Director	5. Social Security Number 215-26-2142 Usual Rasidance of Decedant 6. Sax, 7. Aga (In yrs. last birthday) 8. Sax, 7. Aga (In yrs. last birthday) 9. Wonths 9. Days 9. Hours 9. Min.	8. Data of Birth (Month, Day Aug. 6,	Year) 1923	9. Birthplace (State or Foreign Country) Maryland							
Marylend Fed at	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yas X No							
th with the	10e. Street and Number 10f. Zip Code 11609 Mathews Road 21757	1	Og. Citizen of Will United								
Baltimore, Maryland 21215-0020 semit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show iny injury or other traumatic event, the Marical Evantinan must be notified.	11. Marital Status 12. Was Decedant Evar in U.S. Armed Forces? 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedant Evar in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerlo 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)		- American Indian, Whita, etc. White							
yland 21215-01 uld be filed within 72 ho Mental Hygiene. riked other than "nature title event, tre Medical.	15. Decedant's Education (Specify only highest grade completed) (Give kind of work done during most of work	ina	16b. Kind of Bus	iness/Industry							
within ene.	(Specify only highest grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Gâire kind of work done during most of work life. DO NOT use retired)	9									
filed w	Farmer		Dairy								
Maryland 2 12 should be filed w h and Mental Hygie 7 is marked other th traumatic event, to	17. Fathar's Nama (First, Middle, Last) 18. Mother's Name	a (First, Middle, I									
should be nd Mental marked o		and the same of		Main							
Ma d2 st h and 7 is n traun	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Run.										
10re, Maryland 212. ges 1 and 2 should be filed within to f Health and Mental Hygiene. If flem 27 is marked other than or other traumatic event, tre. H	Frances V. Crum / wife 11609 Mathews Rd. / Key 20a. Mathod of Disposition 20b. Place of Disposition (Name of		_	21757 Sity or Town, Stata							
Peges nant of I	Burial 2 Cremetion 3 Ramovel from State cemetary, crematory or other place)										
Baltimo				town, Maryland							
Dealt. Departiments		auffer E									
	Daymon (Yelesson 40 Fulton Ave. / Wa										
	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or reart failura. List only one cause on each line.	or respiratory arm	est,	Approximata Interval Between Onset and Death							
Physician // /Medical	Immediate Cours (Final			F-1							
Examiner	Immediata Causa (Final disasas or condition rasulting in death) a. Lethroughur Accide	1		5 days							
	Dua to (or as a consequence of):										
pen nsin	b			1							
al-tre	Sequentially list conditions, Dua to (or as a consequence of): if any, leading to immediate										
anth certificate be executed attending physicien and for use as the burial-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disassa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):										
ficate to by											
eath certi	d										
death death death death	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did to	hacco use cont	ribute to the cause of death?							
detached	Tarti. Other alginican conditions continuing to death out not resulting in the discensiving cause given in Fart.	1□Y	V	3 Probably 4 Unknown							
s that s det	atrial tehrillating										
of Attending Physician: The lew requires that the death cert after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use entitlication: To Be Completed by Director.	hypertensin	24a. Was a perform	n autopsy ned?	24b. Were autopsy findings available prior to completion of cause of death?							
VICAL THE IOW SCHILLINGS CONTINUES CONTIN		1 Y	s PONO	1 ☐ Yas 2 Ø No							
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tal or Attending Phy Is after death. al Director: After this led in by the funeral of	27. Mannar of Death 28a. Data of Injury 28b. Time of 28c. Injury 38c. Injur		ow injury occurre								
Attended deat y the	2 Accidant invastigation 3 Suicida 6 Could not be datarmined 28a. Plece of Injury - At homa, farm, street, factory, office			r or Rural Routa Number,							
din din din	4 ☐ Homicida building, a(c. (Specify)	City or Town	n, State)								
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page.	29a. Cartifier (Check only one) 129 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and manner stated.	and due to tha c red at the time, d	ause(s) and man ata and place, ar	nar as stated. nd dua to the cause(s)							
vithin ro th	29b. Signatura and titla of certifiar 29c. License number	2		(Month, Day, Year)							
->-0	Custin (12 0,568) D 09689		12/13	3/99							
AGAIN S	30. Nama end addrass of person who completed causa of pean (Item 23a) (Type, Print)		.,,	/ ()							
	Austin Pearre, Jr. / 300 W. Ninth St./ Frederick, N	Marvland	21701								
State	31. Data filed (Month, Day, Year) 32. Registra/s Signatura	Jaanu									
Registrar	10-111111111111111111111111111111111111										

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

			1		Ce	ertifica	te of L	Death		Reg. No.	9 4	0810
Physician	1. Decedant's Nama (st)	G1	1.5				2. Data of De Month	Day	Yaar	3. Tima of Death
/Medical	nere.		-0.00		ase	_	f		Decemb		1999	1:00 P.
Examiner									or Location of Deat			
	Calvert 5. Social Security Num			Center 7. Aga <i>(In yr</i> s		il If Und		Fince E	rederick	ta.	lvert	(Ct-t
-uneral Director	220-28-500 Usual Rasidance of De	9 1	_M 2∑F	7. Aga (III y/s	78 Yrs.	Months		Hours M	Aug. 1	on th Year) 0, 1921	9. Birthpie Countr Mary	aca (Stata or Foraign 7) Land
ž		0b. County		10c. C	ity, Town or I	Location					10	d. Insida City Limits
of Po	Maryland	Calvert					ederi	ck				1 ☐ Yas 2 No
be notified be notified Director	10e. Street and Numb	er				10f. Z	ip Coda			10g. Citizan of	What Countr	n/2
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			Armed For 1 ☐ Yas If Yas, Giv Yaar or Da	2X No			ecify Cubar 20 No		(Specify Yas or No erto Rican, atc.)		ck, White, at y: Blac	
ted pat	15	. Decedent's Ed	lucation		16e. Dec	edant's Us	ual Occupa	tion		16b. Kind of 8	usiness/indu	ıstry
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Department of heath and wer important: If them 27 is marke any injury or other traumatic once.	19a. Informant's Name Margaret G								Aural Routa Numb I Hunting			
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eny ir	> place	eq. x	Sevel	(MD 20678
nding physician end use as the burial-transit	Causa (Diseasa or Inju that initiated evants rasulting in death) Las		c. s/P	Dua to (or as a conse	equanca of):					
offer use			d	N'8 UM B	diot	encu					1	
the ett	Part II. Other significa	nt conditions of	ontributing to de	ath but not ras	sulting In tha	undarlying	causa giva	n In Part I.	23b. Dld	tobacco use co	ntribute to t	the cause of death?
signed by the ettend d be deteched for us d by Physiclan/	Urose	185							10	Yes 2□No	3 Probe	ably 4 Unknown
or o										an autopsy	24b. War	e autopsy findings
s been si should	477								pend	ormed?	com	labla prior to pletion of causa eath?
page 2 should	Queria	4							10	Yas 2 No		Yas 20 No
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	axaminer?		Hospitai:	patient 2	ER/Outpatie	ent 3 D	Otha Otha		eath <i>(Check</i> on <i>ly</i> Homa 5□ Ras		as (Casaife)	
ther thi		5 ☐ Panding invastigation	28e. Deta o (Monti	f Injury n, Day Year)	28b. Tima Injury	of	28c. tnjury Work	at as 2 No		how Injury occur		
To the Functial Director: Affect completely filled in by the functional Medical Certification:	3 Sulcide	Could not be datarmined	28a. Place	of Injury - At h g, atc. (Speci	oma, farm, s fy)	treat, facto	ry, office		28f. Location (City or To	Street and Numi wn, State)	per or Rural i	Routa Number,
he Funera pietely fille edical C		Certifying Phy Medical Exam	ysician: To tha latner: On tha ba and mann	sis of axamina	owledga, daa ition and/or l	th occurred	d at tha time n, in my op	ı, dete and pia nion, death oc	ca, and dua to tha curred at the tima,	causa(s) and m data and placa,	anner as star and dua to t	ted. ha causa(s)
ompie Me	29b. Signatura and title	a of certifiar	wite illerill	- olutou.		29	c. Licansa	number		29d. Data signe	d (Month. Di	ay, Year)
- 8	De De	20	MD					502	90	12 -		
	20 No.	THILL SHE		-4.4				J J 4	1 -			, ,
	30. Name end addrass	or person who o	complated cause	of death (Ite	n 23e) (Type	, Print)						
	DHIREN	SHA	H, M. E).			PR	INCE	Prepare	ICIS N	O	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			State of Maryla		Certificate of			Reg. No.	9 40	811
	Physician	1. Decedent's Name (First, Midd		Kı	Roney		2. Dete of De Month	Day	Yeer 3. 1	Time of Death
lg.	/Medical Examiner	4a Facility Name (If not institution		_ / \ /	copey	4b. City, Town, or L	ocation of Deet		of Deeth	1755
			undel Ger		OSpitAl		+polis	A	A	
	Funeral Director	5. Social Security Number 066-30-5794 Usuel Residence of Decedent	6. Sex 1 XM 2 F 7. Age (In y		If Under 1 Year Months Deys		Month, De Feb 12	y, Year)	9. Birthplace (Country) New Yo	State or Foreign
	yland	10a. State 10b. County	10c.	City, Town	or Location				10d. in	nside City Limits
	Ba-fat		Arundel	Arno	ld					☐ Yes 24☐ No
	ifter death with the Maryland r items 23s or 28s-f show here must be in tifted at Funeral Director	10e. Street and Number 541 Bay Green I	rive		10f. Zip Code	21012		10g. Citizen of V USA	Vhaf Country?	
21215-0020	ors after bit, or its Examine by Fui	11. Maritel Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Vac Giva		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No Rican, etc.)		a - American Ind k, White, etc. : White	tian,
5-0	72 ho matur ofical	15. Deceder (Specify only highe	nt's Education st grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ding	16b. Kind of Bu	siness/Industry	
121	be filed within 72 ho tal Hygiene. d other than "natura event, the Mactical Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		G. Coast Gu			Mil	itary	
pc	be filed with tal Hygiene, d other than event, the Be Comp	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle	, Maiden Sumem	e)	
ylaı	should be nd Mental marked o urnatic eve	William DeKron	*			Anita	Pats			
Maryland	d 2 sh th and 7 la m traum	19e. Informant's Name/Relation: Will DeKroney			Malling Address (Stree 200 Quaker I					,)
Baltimore,	uchit, Pages 1 an Pagartment of Heal Important: If Item 2 Iny Injury or other Ince	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation	3 Removel from State	b. Place of cemeters	Disposition (Name of y, crematory or other plater	nce) De	2C Date 13	20c. Location - Crownsv		
altin	vernit, Pa Departmen moortant: my injury dos	4 □ Donation 5 □ Other (5 21. Signature of Fundral Service	topism)	D VEC	22. Name and Addre	-				
Ö	Deg me	MAL	4 Sur	_	Barranco & 495 Gov. For enter the mode of dy	& Sons, P.	A. Seve	erna Par	k Funer	al Home
(8760,	Arificate be executed Applysician and tas the buriel-transit Aedical Examiner Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf	cDue to	o (or as e c	onsequence of): erotic onsequence of): onsequence of):	Arrhu Heart	Jthm Disa	'A CAS-e-		el and Death
Box	attending parties as as as action of the use as action of the contract of the		d							
P.O.	es that the death certigned by the attending be deteched for use by Physician/N	Part II. Other significant condition Diabete	ons confributing to death but not $5 $		the underlying cause gi	iven in Part I.		tobacco use coo Yes 2□ No	ntribute to the 3 ☐ Probably	
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of	Attending Physician: r death. ector: After this certific by the funeral director, ffication: To Be (176 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	28b. T	patient 3L DOA			how injury occur		
on	oding tth. : After a fune	1 Neturel 5 ☐ Pendi			jury Wo	ork?]Yes 2∐No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division of	tal or Attending P ins after death. si Director: After t lad in by the funera Certification:	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide determ			rm, street, factory, office)	28f. Location City or To	(Street and Numb wn, Stete)	per or Rural Rou	ite Number,
	To the Hospital or Attending Physician: Tha I within 24 hours after death. To the Funeral Director: After this certificeta ha completely filled in by tha funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying (Check only one)	ng Physician: To the best of my l Examiner: On the basis of exam end manner stated.	knowledge, nination and	death occurred at the t Vor investigation, in my	ime, date and place opinion, death occu	, end due to the rred at the time	ceuse(s) end me date end place,	enner as stated and due to the	cause(s)
	within To th comp	29b. Signature and title of certific	RAD	epu	29c. Licen	se number	54	29d. Date signe	d (Month, Day,	Year)
		30. Name and address of person	who completes cause of deeth (Item 23a) (Type, Print) 695	Ame	MÓR	Of.	2103	5
	State	31. Date filed (Month, Day, Year	32 Pegistrar's Si		6 1	1			NI V	

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North Allegan and Allegan and the second of
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Joshua Durrance State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 1999 Joshua Ehren December 11 10:15 AM. Durrance /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Howard County General Columbia Howard Months Days Hours Min. Aug. 22, 1976 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months XXM 2□ F Kentucky 23 212-94-9050 Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Harford 1 XYes 2 No Directo Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 466 Bonnett Street 21001 23 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Black, White, etc. filed within 72 hours after Never Merried 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 20XNo Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Student College 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 1 and 2 should be fill tealth and Mental H m 27 is marked off Be James Durrance, Jr. Betty Simon and) 19e. Informent's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Hea James Durrance, Jr. 30 Canning House Lane, Conowingo, Maryland 21919 parmit. Pages 1 a Department of Hea Important: If Nem any Injury or othe 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Harford Memorial Gardens 12/15/99 Aberdeen, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fuperat Service Licansee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete tntervel Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical AND NOCK THUMOS Examiner Due to (or es e consequence of): Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): use as the burial-tre Box 68760 Due to (or es e consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 25 No 3 Probably 4 Unknown signed be del Division of Vital Records. PV 24b. Were autopsy findings eveilable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes Yes 2 No 2 No certificate funerel director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: VO npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 X Yes 2 No Certification: To this 27. Menner of Deeth 28d. Describe how injury occurred MININAN 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturet 2 Accident 1802 PM DRIVEN OFCON INCOLLINGUIA s after death. 1 Yes 2 No 12-10-49 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homicide 8 RODDWY

63 | CEDAR USW HOWA M CO

1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end menner es stated.

**The dicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 6631 CEDAR LAWS HOWAMPCO. MU 24 hours Medicai 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier. O.C.M.E. December 13, 1999

State

Registrar

HARDONOA Wordow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

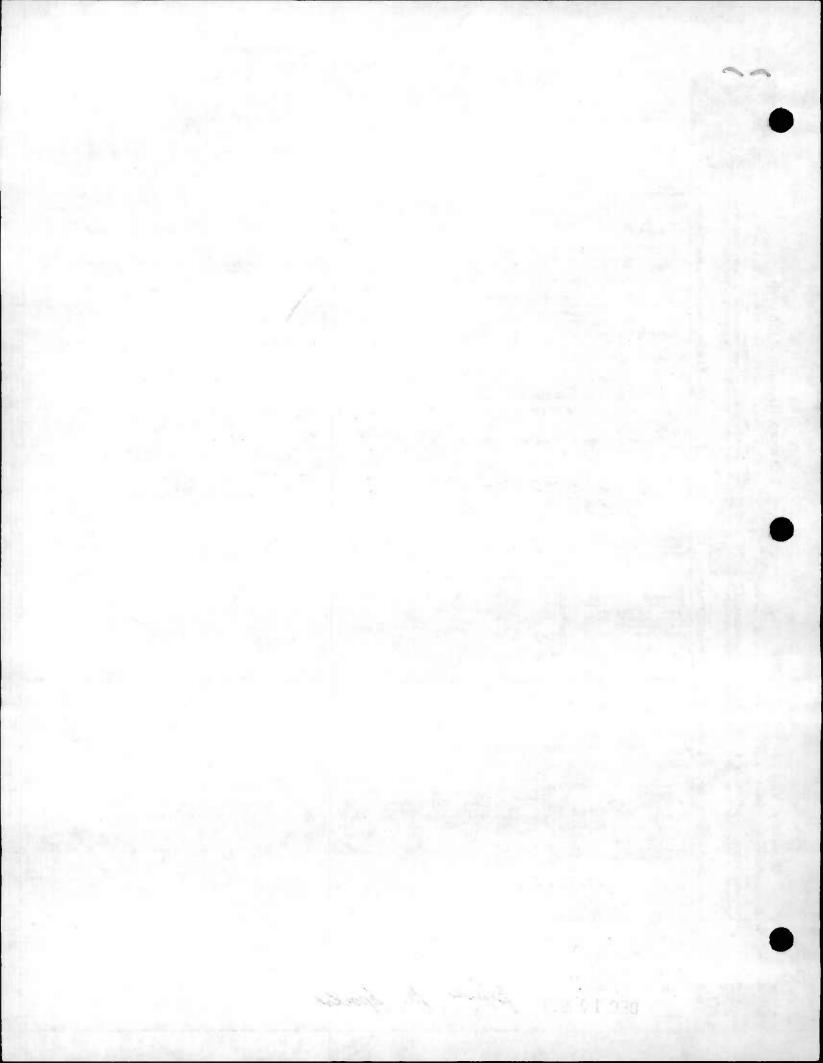
111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Dey, Year) 32. Registra s Signeture 1999 ▶

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	Amended #14,19b,20		CHD HLC	Ce	rtificate of	Death		Reg. No.	9	40813
ysician Medical	Nellie M.						2. Dete of De Month	Day 09	Year 99	3. Time of Death OZ:37
aminer	4a Facility Nama (If not institu					4b. City, Town, or Lo		4c. County	of Death	
	UNIVERSITY					BALTIN If Under 24 Hrs.				
ral tor	5. Social Security Number 228-24-0823	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 7.2		Months Days	Hours Min.	8. Data of Bir (Month, Da Nov •	th ly, Year) 27,1921	9. Birth Cou	placa (Stata or Forei intry) Virgini
	Usual Rasidence of Decedent 10a. State 10b. Cou	nty	10c. Cit	y, Town or Lo	ocation					10d. fnside City Limi
lo	DE	KENT		MAGI	NOLIA					1□Yes 2⊋N
200	10e. Street and Number			111101	10f. Zip Code			10g. Citizen of	What Cou	intry?
<u>単</u>	273 CHERF	Y DRIVE				19962		Ţ	JSA	
by Funeral Director	11. Marital Status 1 Never Married 2 I 3 Widowed 4 Divor	Armed F ferried 1 ☐ Yas	2 No		Was Decedent of I If Yas, specify Cub 1 ☐ Yas 2 ☐ No	dispanic Origin? (Spe an, Mexican, Puarto I Specify:	ecify Yas or No Rican, atc.)		e - Amari ck, Whita,	can Indian, , atc. HITE
	15. Dece (Specify only hip Elementary/Secondary (0-1	dent's Education thas t grada completed College	(1-4or 5+)	16a. Dece (Giva lifa.	dent's Usuel Occup kind of work done DO NOT use retire	pation during most of worki d)	ng	16b. Kind of B	usiness/In	dustry
	11			(QUALITY	CONTROL		MAN	IUFA	CTURING
	17. Father's Nama (First, Mide		CII			18. Mothar's Nama		AGE TO SERVICE		
	FRANK		GHTY				ILLIAN			
	19a. Informant's Name/Relati		D.D.			and Number or Rura				
	MARY TRICE 20a. Mathod of Disposition	/ DAUGHT			BOX 32	4 HAR	RINGTO	ON, DE		952
	1 Burial 2 □ Cremation		Stata	ematary, crai	matory or other pla	1.1	2/13/	99	City of 1	own, Stata
	4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Serv		SI		HNSTOWN 2. Name and Addre	CEMETER	Y	GRI	EENW	OOD, DE
	* Lugar	the state of the s	>	- 1	FLEISCHI POB 502	AUER FUN GREEN	WOOD,	DE 199	950	
	23a. Part1. Enter the disease shock, or hear feilura.	or complications that ist only ona cause on	caused the death each line.	h. Do not en	ter tha moda of dyi	ng, such as cardiac o	r raspiratory a	rrest,	1	Approximete Interval Between Onset and Death
	Immediata Ceuse (Final disease or condition rasulting in death)	. A	scendin	g Aort	be Diss	ection disease				hours years
9		4	Due to (o	M a consec	quenca of):	ATTECE				lkars
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b	Due to (o	r as a consec	quence of):					0 -
		d								
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								an autopsy rmed?	av	/ara autopsy findings vailable prior to ompletion of causa f death?
							10	Yas 2 No	11	☐ Yes 2☐ No
90	25. Was casa refarred to med examiner?	ical				26. Place of Death	(Check only	one)		
2	1 Yas 2 PNo	Hospitel: 1 🗷	Inpatient 2	ER/Outpatier	I 3LI DOA	ner: 4 Nursing Hor	ma 5□Resi	dence 6 □Oth	er (Speci	ify)
Certification:	3 ☐ Suicide 6 ☐ Cot	stigation Id not be	nth, Day Year)	28b. Tima o Injury oma, farm, str	Wo	Yes 2□No				ral Routa Number,
edical	29a. Certifier 1 Certific (Check only one)	ying Physician: To the at Examiner: On the b	e best of my know basis of axaminat	wledga, daatl tion and/or in	n occurred at tha ti vastigation, in my o	me, date and placa, a	and dua to tha ed at tha time,	cause(s) and mo	enner as s	stated. to the cause(s)
M	29b. Signature and title of part		wier stoted.		29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
	X.LI	0.				4498		12/9/		
	30. Nama and address of pers	on who completed cau	sa of death (Item	23a) (Type,	Print)	•	1 1			2.01
0	BRET BOK 31. Data filed (Month, Day, Ye	CHELT, N	10 C	- >, G	REENE	SI DITL	MINOR	MU	212	-01
te ar	DEC 10	1000	Ligibilar S Signa	9.	Sporks	/				

DHMH 16 Rev 6/95



State Registrar

29b. Signature and titla of certifiar

31. Data lited (Month, Day, Year)

Dr. Christopher Snyder

DEC 0 7 1999

DHMH 16 Rev 6/95

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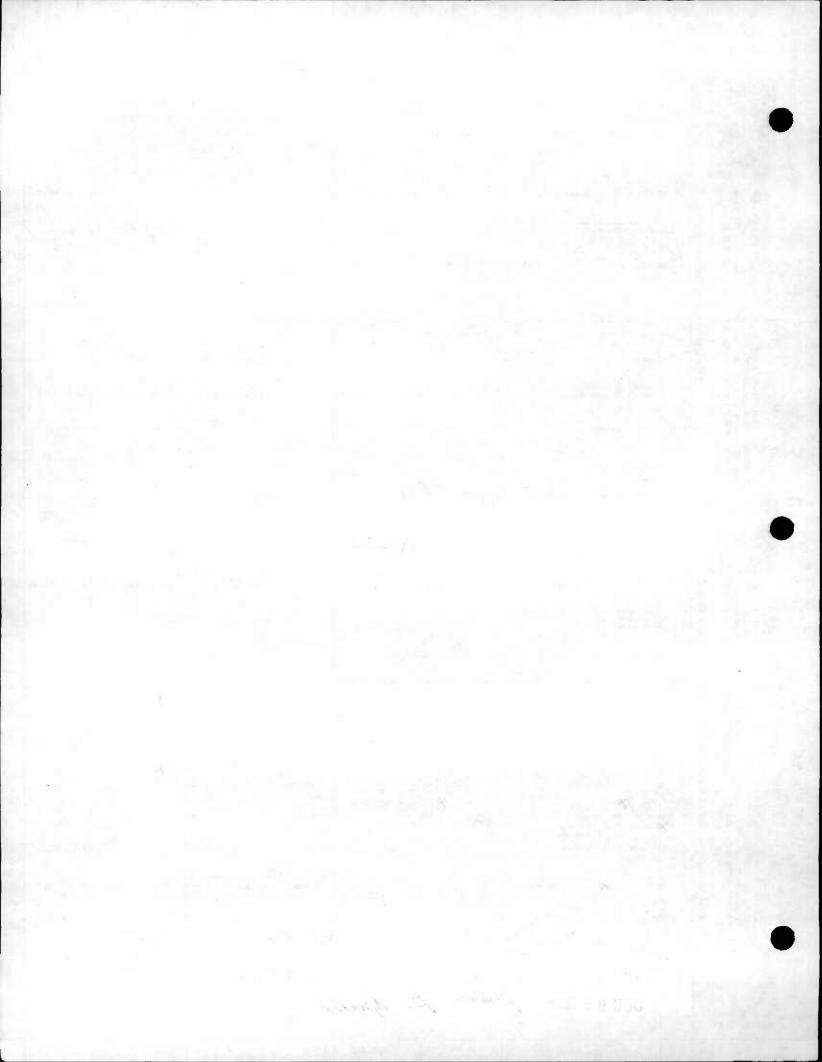
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

H50497

Les 166 Milford St. Suite 201, Salisbury Md 21801
38 Agistrar's Signatura

29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Lillian Virginia Eberhardt December 1,1999 11:30 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Calvert Memorial Hospital Pr. Frederick 5. Social Security Numbar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/22/19 7. Age (In vrs. last birthday) Birthplace (State or Foraign Country) 6. Sex **Funeral** 1 M 2 VF Months Days Hours 80 Director 269-14-4406 Ohio Usual Residence of Decedent 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Yes 2□No Director MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 996 Golden West Way 20657 USA Funeral Hema: 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 14. Raca - American Indian, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. il fled within 72 hours after il Hygiene. other than "natural", or ite 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: ģ Specify: 3X Widowed 4 Divorced white Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 own home Homemaker permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any liny or other treumatic event obtes. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Harry Horne Carrie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8531 Wild Game Lane, Owings, MD 20736 Cheryl Almond/daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dafe 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 12/7/99 Cheltenham, MD 21. Signature of Funeral Service Licensea 22. Nama and Addrass of Facility Raymond Funeral Home, PA Dunkirk, MD 20754 P.O. Box 121, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ANOXIC ENCEPHALOPATHY I Week Examiner Physician/Medical Examiner (Week CARDIAL ARREST The lew requires that the deeth certificate be executed physicien and s the burial-trans Sequentially list conditions, if any, leeding to immediate causa. Enfer Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): awerks Box 68760. Due to (or as a consequenca of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 250 No 3 Probably 4 ☐ Unknown HTN, CHF, HYPER(HULESTROLEMIA Records. ģ 24b. Were eutopsy findings available prior fo completion of cause of death? Be Completed 24e. Wes en eutopsy performed? Diverticulities 1 🗆 Yas 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 1
 24 hours efter death.
 Funeral Director; After this cartilina 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ScInpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 26b. Time of 28d. Describe how injury occurred 5 Panding invastigation Division 1 Solatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - Af home, farm, street, fectory, office building, etc. (Specify) in by 4 - Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date end placa, and due to the ceuse(s) Medical 29a. Certifier and menner stafed. 29b. Signeture and title of certifier my 29c. License number 29d. Data signed (Month, Day, Year) 136969 12/2/95 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.S.Mathew Lusby, MD 20657 32. Registrar's Signature State DEC 03 1999 ▶ Registrar

Committee 2 2 200 80 030

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician DECEMBER 17, 1999 DAVID **EUGENE FAWLEY** 1:33 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 9, 1931 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 214-30-1707 1♥ M 2□ F 68 Yes Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or frame 23a or 28a-f show the Injury or other traumatic event, the Medical Examinar must be notified at once. Maryland Frederick Frederick 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 501 Prospect Blvd., Apt. 24C 21701 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1XO ves 2 No If Yes, Give 1953—1954 Year or Dates: 1953—1954 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Maintenance Heating & Air Cond. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John R. Fawley, Sr. Mary B. Nuse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs. Carol L. Tull, Daughter 4310 Dover Drive, Frederick, Md. 21703 20b. Place of Disposition (Nama of cometery, cremetory or other place)
St. Pauls Lutheran Cem., Dec. 21, 1999 20a. Method of Disposition

*Parall 2 Cremation 3 Removal from State 20c. Location - City or Town, State Jefferson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility. Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial P.O. Box 68760. 100160L 160 BLESHIN Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 1 🖄 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Identifying Physician: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 6

State Registrar

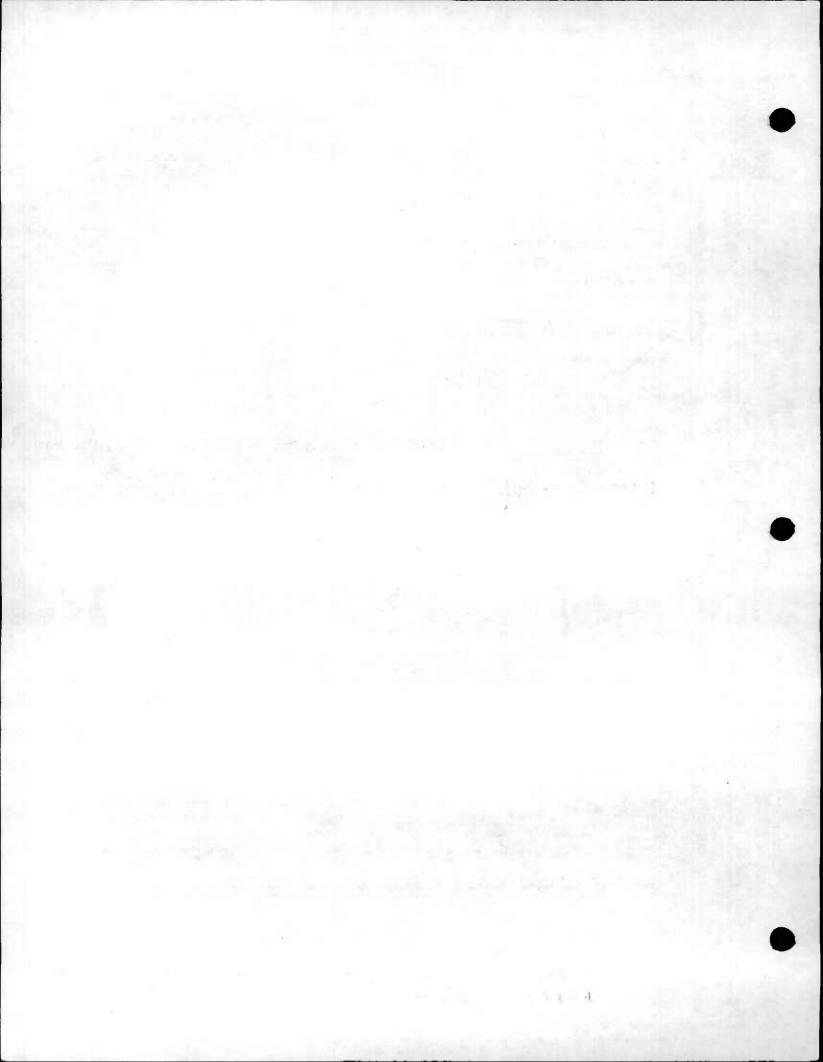
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-MD

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1 Telia Fuller SS# 228-20-35%

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ı	Funeral Director	5. Social Sacurity N		6. Sax 1⊠M 2□ F	7. Aga (In	yrs. last birthday, Yrs.	Months Days			ay. Year) 1916	9. Birthplaca (Sta Country) North Cal	ta or Foraign
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	free death very free must	11. Marital Status	LS NOAU	12. Was De	cedent Evar	in U,S. 13.		Hispanic Origin? (ban, Mexican, Pua	Specify Yas or N		e - Amarican India:	٦,
20	or he				2 ⊠ No		1 ☐ Yas 2 ☒ No		no moun, atc.,	Specify		
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io	Attending or deeth. ector: After by the fune	1 Accident	5 Pending invastiga	ition	onth, Day Yea	r) injury		Yes 2 No				
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	the Hospit In 24 hour the Funer splately fill			xaminer: On tha				time, date end place opinion, deeth occ			anner as stated. end due to the cau	se(s)
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	State Registrar	31. Dete filed (Mont	0 7 19	99 3	yegistara s	ignatura 9.	sporks			2		
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Harold, Mary

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Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Deys	If Under		ate of Birth fonth, Dey, Y		-	(Stete or Foreign
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pue ***	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City	y, Town or Lo	cation					10d. I	Inside City Limits
fled within 72 hours after death with the Merylend Hygiene. Her than "natural", or items 23s or 28s-f show int, the Medical Examinat must be notified at the Completed by Funeral Director.	MARYLAND ANNE ARU	NDEL AND	NAPOL	TS						1 ☐ Yes 27 No
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r Homs 234 place must Funeral	, A	Ves Decedent Ever in U, Armed Forces?	S. 13. V	Was Decedent of f Yes, specify Cul	Hispenic Ori ben, Mexicar	gin? (Specify Y n, Puerto Rican	es or No- , etc.)		e - American II k, While, etc.	ndien,
by F	1	Yes 2 No Yes, Give Yeer or Detes:	1	1 Yes 2 No	Specify:			Specify	BLA	CK
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merke imetic To	19a. Informent's Name/Reletionship (Type, F	Print)	19b. Mailin	ng Address (Stree					Stete, Zip Coo	Je)
27 le er tra	CHRISTINA GREEN (GRANDAUGH	PER) 8	8218 MA	RLTON	CT.	SEVER	N, MD	. 211	44
r oth	20e. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ Remo	20b. P	lace of Dispo	sition (Neme of netory or other pl	ece)	Det			City or Town,	
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	30. Name end eddress of person who comple	eted cause of death (Item	23e) (Type,	Print)		C-1.	17		lan 1	1) 3 100/1
	KOFI BURT	by, 31	9 1	roy.	b	512	170	W N J	1) ANI	U 2100)
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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** JULIAN S. HALL, SR. 7:10 PM DECEMBER 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex XZM 2□ F 8. Dete of Birth (Month, Dey, Year) Dec. 20,1926 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Yrs. 72 212-20-9656 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2X No Directo Maryland | Anne Arundel Harwood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? , or hams 23s or 2 3611 Solomons Island Road 20776 USA deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiena. Important: If item 27 ia marked other than "natural", or itial any injury or other traumatic avant, the Medical Execution. 1 Never Merried 2 Married 21215-0020 1□ Yes XXNo Specify: Specify: White If Yes, Give Year or Dates: W.W.II þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th College (1-4or 5+) Supervisor Data Processing Baitimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Thomas Hall Margaret Marie Schollian 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis M. Hall/ Wife 3611 Solomons Island Rd. Harwood, Maryland 20776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State Lakemont Meml. Gardens 12-16-99 Davidsonville, MD 4 ☐ Donetion 5 ☐ Other (Specify) George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Peri1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · SUBARACH NOID HEMORRHAGE 24 HRS Examiner Due to (or es e consequence of): Phyalclan/Medical Examiner HYPERTENSION or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760 Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy lindings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation s after deeth. Il Director: Aft ed in by the fur 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide

State Registrar

filled in by

To the Hospital of within 24 hours at To the Funeral D completely filled is

4 I Homicide

29b. Signature and title of certifier

BARBARA

29e. Certifier (Check only one)

31. Date filed (Month, Day, Year) DEC 1 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Xande

FRANKLIN STEET ANNAPOLIS MD ALEXANDER 64 32. Registrer's Signeture

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D50016

29d. Date signed (Month, Dey, Year)

December 12, 1999

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State of Maryland / Department of Health and Mental Hygiene

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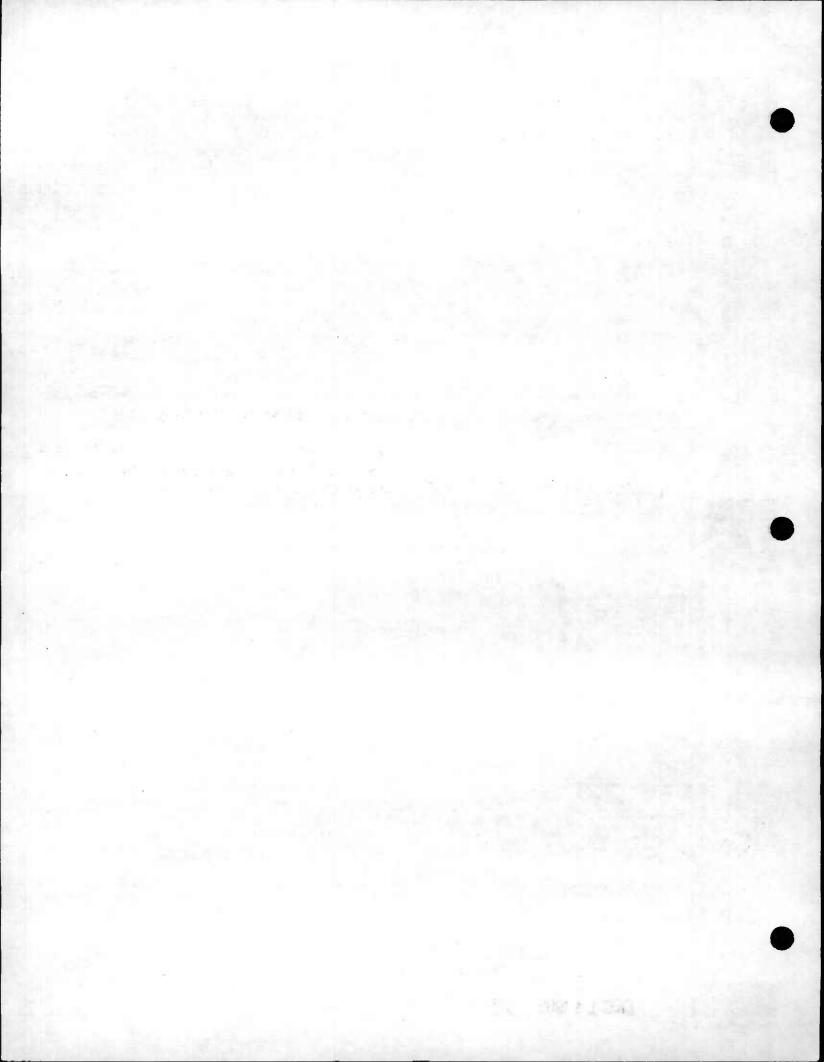
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Director	MD Anne Ar	undel	Mille	rsvi	lle					1 ☐ Yes 2 🔀	
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3	11. Marital Status	12. Was Deced	ent Ever in U,S.	13. V	Vas Decedent of Yes, specify Cu	f Hispanic Origi uban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rad Bta	ce - American ck, White, etc		
	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat		1	□Yes 2 N	o Specify:		Specif	y: W	hite	
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	17. Father's Name (First, Middle, La Ronald Haile	St)				100000	s Name (First, Middl Dara Greav		пө)		
	19a. Informant's Name/Relationship	(Time Brief)		Ob Mailie	a Address /Ctra		or Rural Route Num		Ctata 7ia C	adal .	
	Ronald Hines /						way, Mille			21108	
	20a. Method of Disposition				sition (Name of natory or other p		Date	20c. Location			
	1 ☐ Burial 2 ☐ Cremation 3		Metter /	and the second second			Dec 14	Baltimo	ore, M		
8	4 Donation 5 Other (Specify) Metro Crematory 1999 Baltimore, 21. Signature of Farmul Service Licenses 1999 Baltimore, Parranco & Sons, P.A. Severna Park Fr										
Medical Examiner	Immediate Cafise (Final disease or orhofition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as Due to (or as	a consequ	uence of): uence of):						
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Ž	29b. Signature and title of certifier	and manne			29c. Lice	nse number		29d. Date signe	ed (Month, De	ıy, Year)	
	Many 2 D	arlan	an		DZ	823	9	12/	14/99	7	
	30. Name and address of person who Nancy Davidso	o completed cause	of death (Item 23)	a) (Type, F	Print)	, Cente	9 Bat	fimore	mo	2128	
State		32. 9m	gistrar's Signatura		11						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Dianna Hathaway 15,1999 December 6:54 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Min. May 14, 19 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2X)F 49 Yrs. Director 552-86-5137 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 31 West Patrick Street 21701 U.S.A. "natural", or items 23s 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager Dept. Store permit. Peges 1 end 2 should be file Department of Health end Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event Alba. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Roger Duke Olga Vizego 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 75 Apple Way, Frederick, Maryland 21703 Roger Hathaway (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 12/16/98 mithsburg, Maryland Smithsburg Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause our th. Do not enter the mode of dying, such es cardiac or respiratory errest, Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Neumonia Examiner Due to (or as a consequence of): Examiner Multiple Scierosis The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician P.O. Box 68760 Physician/Medicai the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy Osteo perosis completion of cause of death? 2 12 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 MNatural 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 12-15-99 36610 laward offen mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward F. Fisher, 56 Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 1 6 1999

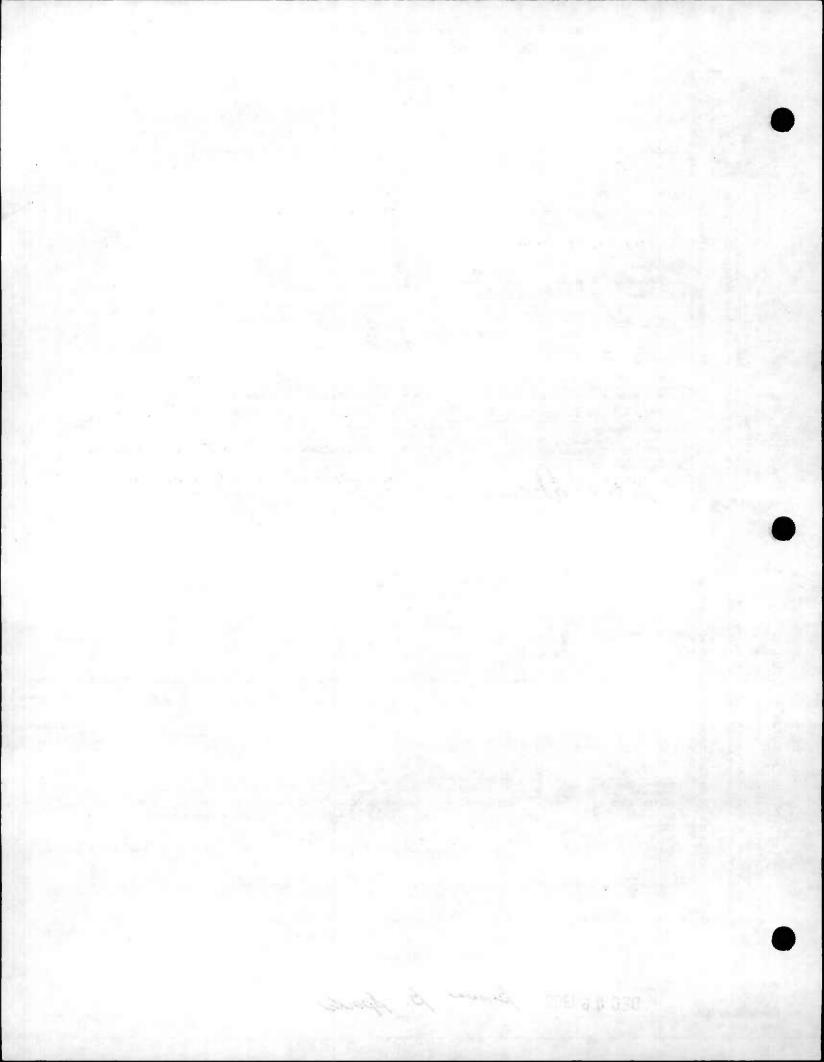


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Superior of Fundament Superior Superio	M P P P	19a. Informant's Name/Relationship	(Type, Print)	19b. N	Aailing Addra	ss (Street	and Number or R	ural Routa Numi	per, City or Town,	Stata, Zip Coda)				
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Holloway Funeral Home Professional Association Sol Snow Hill Rd., Salisbury, MD 21804 Part H. Enter the disease of completations that detect the deeth. Do not enter this mode of dying, such as cardiac or respiratory areas. Part H. Marketing to conditions as consequence of):	0 = 5		Hemoval from Stata					12/3/99	Salisb	ury, MD				
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Nath Nath Nath Nath Nath Nath Street No. 230. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) NATION V 166 MUFORD STREET NO. 24 FO 4	a after dea M Director ed in by the Certifice	3 Suicide 6 Could not	be 28a. Place of Injury	- At homa, farm Specify)	, street, facto	ory, office				er or Rural Routa Number,				
Nature 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) NATESAN V 1/4 MUEDRO STREET MD 4/504	n 24 hour Ne Funer plately filli edical	(Check only 2 Medical Exa	miner: On the basis of ex	aminetion end/o	leath occurre or investigetion	d at tha tin	ne, date end plece pinion, death occi	e, end due to the urred at the time	ceuse(s) end me , date end place,	enner es stated. and due to the cause(s)				
30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) NATESAN V 1A4 MUEDRO STREET MD 4 FO 4	To the	29b. Signature and titla of certifier			2	9c. Licens	a number		_					
4+ NA NATESAN V 106 MUEDRO STREET, NO 4504		> Nataw				847	094		12/31	194				
	4+IVA	30. Nema and addrass of person who				218	04							
	State	31. Data filed (Month, Day, Year)			1 110		1							

DHMH 16 Rev 6/95

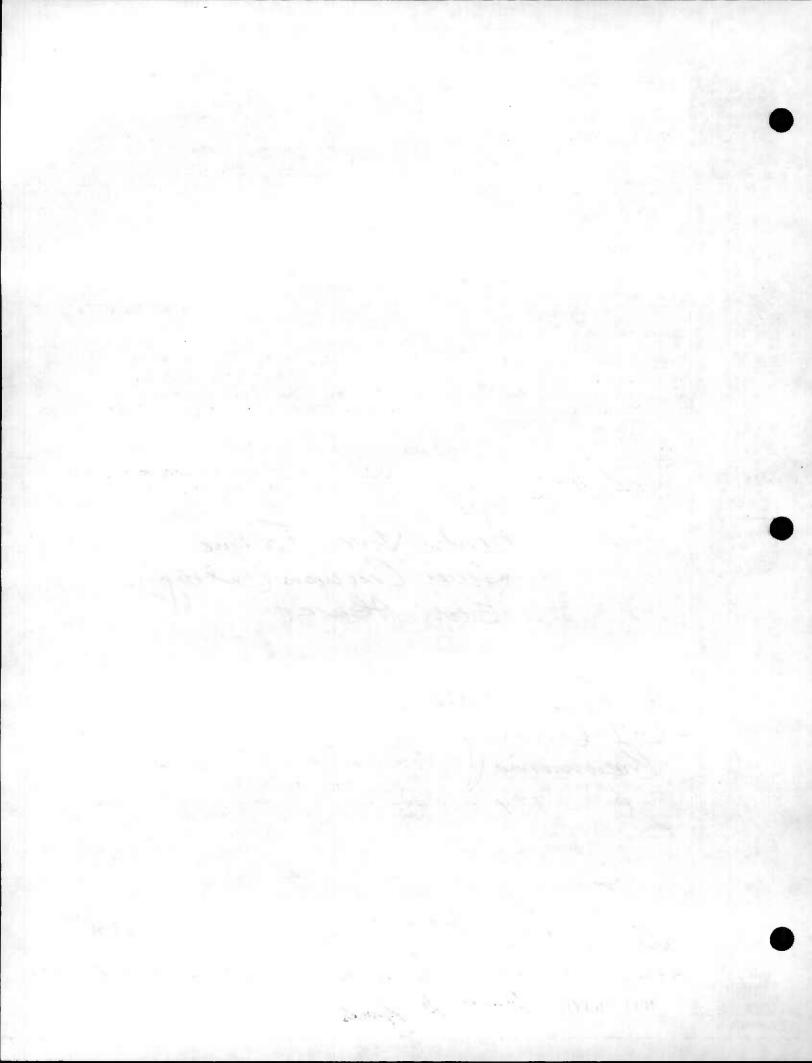
Richards Hallock



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						(Certificat	e of	Death		Reg. No.	1 4	1823	
			1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Yea		Voor	3. Time of Death		
		Physician /Medical Examiner Funeral Director Director	BILLY THORTON				HAMBRICK			NOVEMBER 29,1			0140	
			4a Facility Name (If not instituti	on, give street end n	mber)				4b. City, Town, or	Location of Deatl	4c. Cou	nty of Death		
			PENINSULA REG	IONAL MED	ICAL CEN	TER			SALISB		W	ICOMIC	00	
			5. Social Security Number	6. Sex	0.,		Months Days			8. Date of Bir (Month, De	th v. Year)	9. Birth	place (Stete or Foreign	
			234-48-9122	1 X M 2□ F	66	Yr	rs.			May 5,			Virginia	
			Usual Residence of Decedent 10a. State 10b. Count	v	10c Cit	v Town	or Location					1	10d. Inside City Limits	
													1 ☐ Yes 2 ☑ No	
			TREE FIGURE 1											
		r items 23 document	4957 Scotty Rd. 11. Marital Status 12. Was Decedent Ever in U.S			S						lace - Americ	can Indian	
Y		her d		Armed Forces? 1 Never Married 2 Merried 1 X Yes, Give 3 Widowed 4 Divorced Yeer or Detes:			S. 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican				E	llack, White,	White, etc.	
210	020	of, or				1 ☐ Yes 2 No Specify:					Spe	city: Wh	ite	
bric	5-0020	within 72 hours after ene. then "natural", or ite ise Medical Essentia empleted by Fur		15. Decedent's Education			16a. Decedent's Usuel Occupation				16b. Kind of Business/Industry			
43	21	ed within 72 ho ygiene. For than "natural, it, the Medical Completed	Elementary/Secondery (0-12)	(Specify only highest grade completed) (Give kii ementary/Secondery (0-12) College (1-4or 5+)			life. DO NOT us	e kind of work done during most of working DO NOT use retired)						
47	7	d with giene.	12 - Press Operator Moores Business						ness Forms					
-4	Pu	EIFE O	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme)											
1,4	ylan	Men affice	James Thorton	Hambrick					Emma	a Franci	s Cart	er		
~ 5	lar	Shend end end	19a. Informant's Neme/Reletion				_		end Number or Ru				Code)	
2-2	2	f Health frem 27 I other tr	Michael Hambr	1ck/Son					on Dr.,		-			
73	altimore	Se of L	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation	3 □Removel from		lace of D emetery,	Disposition (Nen cremetory or o	ne <i>ot</i> other ple	ce)	Date		n - City or To		
-	Ë		4 Donation 5 Other (Ri	.verv	riew Cer	nete	ry	12/3/99	Alder	son, W	V	
B	Ball	parmit. Pag Department Important: I any injury o	21. Signeture of Funeral Service Licanopte											
	144	40588	501 Snow Hill Rd., Salisbury, MD 21804											
		Physician /Medical Examiner pnulal-transit	23a. Part 1. Enter the disease, or complications that cause it he deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between											
			Onset and Death											
			Immediate Cause (Final disease or condition A Curke Twee Failure											
	п		resulting in death)	8.	Oue to (o	r as a co	insequence of):	,		/	1	\		
	Н			0	Time	· L	Ciu	le	esis (5ul 1	Cape)		
			Sequentially list conditions. Due to (or es e consequence of):											
	60,	cian curial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.											
	68760,	physician as the buria	that initiated events resulting in death) Last Due to (or as a consequence of):											
	Box	ding p		d								1		
		attendir for use										I		
		by the leched	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death?					
	P.0		- Ac KA	1	Forie	en	1.			1 Yes Probably 4 Unknown				
	S,	signed d be de	- GI bleeding							24a. Was an autopsy performed? 24b. Were autopsy tindin available prior to completion of caluse				
	0	been should												
	3ec	hes to pe 2 s			. //						of	of death?		
	of Vital Records,	Cor	- meur	nome						10	Yes Sen	1	□Yes 2□ No	
	Vita Vita	Attending Physician: The introduction of deeth. setor: After this certificate he by the funeral director, page	25. Was case referred to medic examiner?		1			-		ath (Check only	one)			
	of		1 Yes 22 No		Inpatient 2			^		Home 5 □ Resi			(y)	
	n C	After funer	27. Manner of Death Pand Pend	11134	of Injury oth, Day Year)	28b. Tim tnju	ne of 2	8c. Injui		28d. Describe	now injury oc	curred		
	Sic	deeth deeth y the	3 Suicide 6 □ Could		a addalas a Auto				Yes 2 □ No	294 Location /	Circot and Mi	mbor or Pur	of Bouto Number	
	Division	tal or Attending P is after deeth. of Director: After t led in by the funera Certification:	4 ☐ Homicide deten	mined 286. Plac	ing, etc. (Specify						ocation (Street end Number or Rurel Route Number, City or Town, Stete)			
		ours erel filled	29a. Certifier Certify	na Physician: To the	heet of my know	wladaa d	death occurred	at the tir	no date and place	and due to the	cauca(e) and	manner ac a	stated	
		To the Hospital or Attenumin 24 hours efter deet To the Funeral Director: completely filled in by the	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only and manner is stated. (Check only and manner is stated.) (Check only and manner is stated.)											
			29b. Signature aper title obsertifier 29d. Date signed (Mooth, Day, Year)											
4			V/(\)	10	1 An	cer		~	7611		111	9/1	0	
		., 14	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	6	Le) IV	K421 (K4	An I	7-6	1	11/11/2	e	Do 1	Polis	inne	11.	1 21001	
	, W	State	31. Date filed (Month, Dey, Year) 32.1	Registrar's Signe	ture	· Cuna				7	1015	ر مهدا.	
		Registrar	NOV 3 0 190		wa	4	1.	,						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dev Nellie Hoskins 6, 1999 4c. County of Deeth 4b. City, Town, or Location of Death 1:40 PM 4a Facility Neme (If not institution, give street and number) Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 18, 1928 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 XF 216-40-4307 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Pittsville Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35540 Laws Rd. 21850 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th laborer Poultry 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Etta Mary Whittington Robert Baine 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Smith/daughter 406 Bailey Lane, Salisbury, MD 21801 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Friendship UMC Cemetery 12/11/99 Snow Hill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death

Physician /Medical Examiner

use as the burial-transit

8

completely filled in by the funeral director, page 2 should

certificate has

this

e Hospital or Attendin n 24 hours after death. e Funeral Director: Att

within 2

To the

Physician

/Medical

10a. Stete

MD

Director

Funeral

Be Completed by

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show you have jujury or other traumatic event, the Medical Examinar must be not an abose.

Baltimore, Maryland 21215-0020

Be Completed by Physician/Medical Examiner Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records.

a Upper G	isspool NT	-087ml 1	Steding	One Day					
Range of	or as a consequence of): ~e_		monord					
Due to (or es a consequence of): c. ADVANCED UTENZINE CANCEN 7 MUNTAL Due to (or es a consequence of): d.									
ntributing to death but not res	ulting in the underlying	cause given in Part I.	23b. Did tobecco use co 1 ☐ Yee 2 ☑ No	ntribute to the cause of death					
			24a. Wes an autopsy performed?	24b. Were autopsy tindings aveilable prior to completion of cause of death? 1 Yes 2 No					
26. Place of Deeth (Check only one)									
Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specity)					
28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red					
28e. Plece of Injury - At he building, etc. (Specif	ome, ferm, street, factory)	28f. Location (Street and Numb City or Town, State)	8f. Location (Street and Number or Rurel Route Number, City or Town, State)						
	b. Due to (c. Architecture) Due to (c. Arch	Due to (or as a consequence of Due to (or es a consequence of	Due to (or es a consequence of): d	Due to (or as a consequence of): Due to (or es a consequence of): C. AD I Arcel UTER! IVE CANCEN Due to (or es a consequence of): d					

12

State Registrar

Michael R. Atkins, M.D. 31. Date filed (Month, Day, Year) DEC 1 0 1999

29b. Signeture and title of certifie

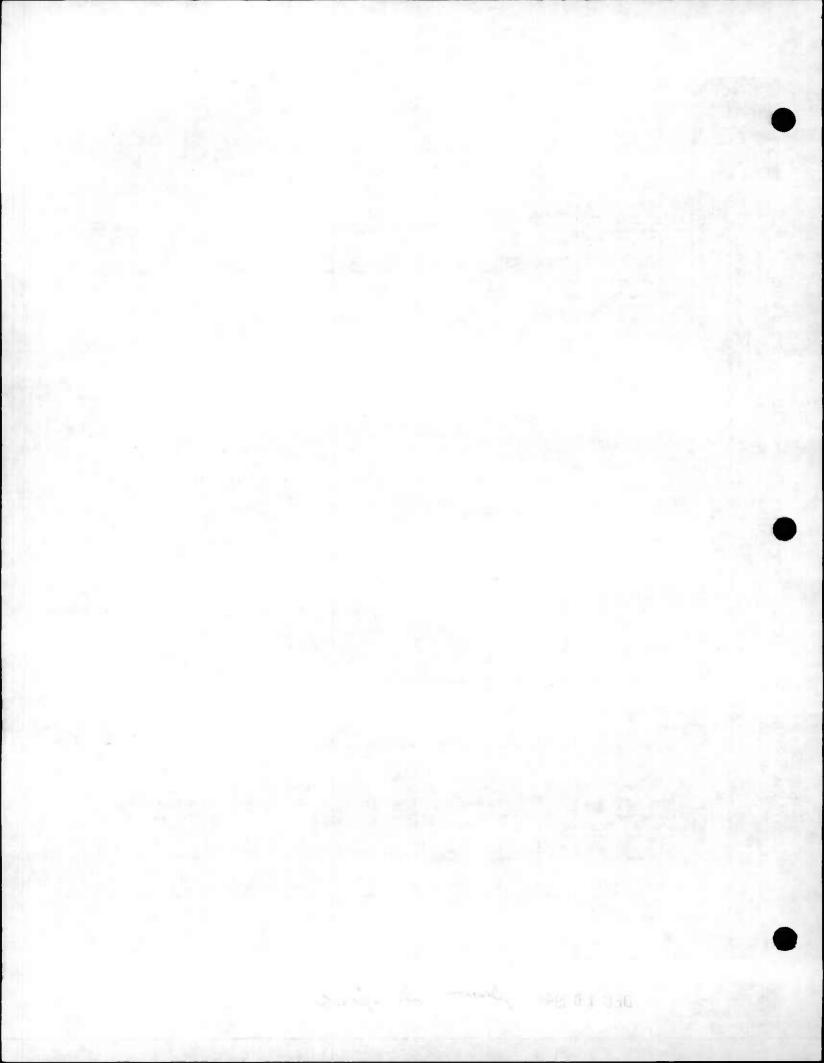
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

1104 Healthway Dr., Salisbury, MD

29c. License number D 39813

29d. Date signed (Month, Dey, Year)

21804



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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Last	st)		2071	ificate of		2. Date of Death		3. Time of Death	
Physicia /Medic		Roland		Ho11	and.			Month December		ear 99 10:45 P.M	
/iviedic: Examine		4e. Facility Neme (If not institution, give	street and number,)			4b. City, Town, or I		4c. County of		
		Millennium Healt		ilita	tion C	enter	Edgewat			Arundel	
uneral rector			9X 7. A(ge (In yrs. le 88	ast birthdey) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 14,	Year) 1911	Birthplace (State or Foreign Country) Mary Land	
ž		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loca	ation				10d. Inside City Limits	
d sho	ō	Maryland Anne Aru	nde1			thian				1 ☐ Yes 2 No	
If flem 27 is merked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street end Number 5430 Sands Road		1		10f. Zip Code 207	11	10	g. Citizen of Wh	at Country?	
E L	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever In U.S	S. 13. W	as Decedent of I	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-		American Indian,	
af, or h	by Fu	1 Never Married 2 Merried 3 X Widowed 4 Divorced	1 Yes 2 4 It Yes, Give Year or Dates:	No		Tes, specify Cub		o mican, etc.)	Specify:	White, etc. Black	
dical	Completed	15. Decedent's Ed (Specify only highest gra-	lucation de completed)		16a. Decede	nt's Usual Occup	pation during most of word d)	kina 1	6b. Kind of Busin	ness/Industry	
han a	du l	Elementary/Secondary (0-12)	College (1-4or	5+)	Cust	o <i>NOT</i> use retire odian	d)		County	Government	
ther tha		17. Fether's Name (First, Middle, Last)					18 Mother's Nem	ne (First, Middle, M			
ked o	To Be	Benson	Н	lo11an	d		Henriet			kall	
traumatic eve		19e. Informant's Name/Relationship (1) Roland A. Holland				Address (Street		ral Route Number, restville			
Important: If Item 27 any injury or other ti once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				ition (Neme of atory or other pla					
Importan any injur once.	-	21. Signeture of Funeral Service Licen		116.	22.	Name and Addre	ess of Fecility Se	well Fune	ral Hom	e	
	_	1 states a	ever							ck, MD 206/8	
sician edical		23a. Part1. Enter the disease, or compshock, or heart tailure. List only of Immediate Cause (Final				NIA		or respiratory arre	st,	Approximate Intervel Between Onset and Deeth	
miner		disease or condition resulting in death)	a/		as a consequ						
At .	ie l		. +	_		ATI	ON.			2 weeks	
trens	Ea	Sequentially list conditions,	D		as a conseque	3					
burie	<u>e</u> 回	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C								
ig physician end es the buriel-trensit	Physician/Medical Examiner	resulting in death) Last		Due to (or	as a conseque	ence of):					
for use	any		d							1	
the eff of be	300	Part II. Other significant conditions co	ntributing to death b	out not resul	ting in the und	lerlying cause gh	ven In Part I.	23b. Did tot	acco uae contri	bute to the cause of death?	
	by Phy	POSSIBLE	LUNG	CA	NCER	- NOT	CON FERMI	1 Ye	8 2□ No 3	Mackall own, State, Zip Code) 20747 Non-City or Town, State derland, MD Home Approximate Intervel Between Onsel and Deeth Q W LOKS 2 W LOKS 2 W LOKS 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Other (Specify) Indinger or Rural Route Number, Indinged (Month, Day, Year) 9 - 9 9	
2 should t	Completed							24e. Wes an perform		eveilable prior to completion of cause	
page 2	E							1 ☐ Yes	2 No		
E 5	e e	25. Was case reterred to medical					26. Place of Dee	th (Check only one	7.		
0.0	0	examiner? 1 Yes 2 No	Hospital: 1 ☐ inpatio	ent 2 🗆 E	R/Outpetient	3□ DOA Oth	10°	ome 5□ Resider		(Specify)	
0 0		27. Menner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Inju	ry et rk? Yes 2 □ No	28d. Describe how	v Injury occurred		
olrector: in by the	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined	28e. Placa of Inj	ury - At hor c. (Specify)			res ZUNO	28f. Location (Str. City or Town,		or Rural Route Number,	
	edical Ce	Check only 2 Medical Exam	reician: To the best Iner: On the besis o	f examination	ledge, death o	occurred at the tile stigetion, in my o	me, dete and place,	end due to the car	use(s) and menn	er as stated. If due to the ceuse(s)	
on the	Mec	one) 29b. Signeture and title of certifier	and manner st	ated.		29c. Licens	se number	29	d Date signed (Month Day Year)	
F 8		lego	- or e	1 0	~	D	5065	3	12.9	- 99	
		30. Name and eddress of person who of 5851 DEALE	ompleted cause of CHURCH	leath (item:	23a) (Type, Pi	rint) Cay	AN.C.	SURAN	10076	1	

..... MILES IN ATTEMPTORY AND ADDRESS OF THE STATE

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State of Maryland /

Department of	Health and Me	ental Hygiene 🥄 🧐

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				Certificate	e of L	Death			Reg. No.		
	1. Decedent's Name (First, Mid	ddle, Last)						2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
Physician	Robert	Clarenc	e Henr	igar							09:20 ar
/Medical Examiner	4e Fecility Neme (If not institut			3	4	b. City, To	wn, or L	ocation of Deet			109.20 01
Laminer	Calvert Memor	rial Hospita	1		I	Princ	e Fr	ederick	Calv	ert	
Funeral	5. Sociel Security Number		. Age (In yrs. last birth	day) If Under Months	1	If Under Hours	24 Hrs.	8. Date of Bir (Month, Da			plece (Stete or Foreign
Director	383-05-5848	Min.	Dec.	24,1919	Mich	nigan					
`	Usuel Residence of Decedent		7 9				1				-0
72 hours after death with the Maryland 72 hours after death with the Maryland status is, or items 23s or 28s f show lines Examined must be notified at steel by Funeral Director	10a. Stete 10b. Coun	nty	10c. City, Town	or Location							10d. Inside City Limits
Man He st	Maryland Calv	rert.	Prince	Frederi	ck						1 ☐ Yes 2 XNo
or 28a-fs to 28a-fs be notified	10e. Street end Number	02.0	111100	10f. Zip					10g. Citizen of	Whet Coul	ntry?
ath with the Marylen 23s or 28s-1 show ust be notified at		76		20	678				U. S	. A.	
ifter death v	14 Morital Status	_	lent Ever In U.S.			ispanic Ori	inin? (Sr	pecify Ves or No			can Indian,
items items	11. Marital Status 1 □ Never Married T T T T T T T T T T T T	Armed Ford	es?	13. Was Deced If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	Rican, etc.)	Ble	ck, White,	
urs aff		If Yes, Give	es: W.W.II	1 ☐ Yes 2	No No	Specify:			Specif	Y: TATE	nito.
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2 2 2 8	17. Father's Name (First, Middl								, Maiden Sumer	ne)	
should be nd Mentel marked c	Warren Henni	lgar				An	na H	loward			
sho m s mu	19e. Informant's Name/Reletio	nship (Type, Print)	19b. I	Mailing Address	(Street e	end Numb	er or Rui	rei Route Numb	er, City or Town	State, Zip	Code)
C = 0 =	Melba Henniga	r	600	4 Dusk	Driv	ve Pr	ince	Freder	rick. Ma	rvlar	d 20678
oth met	20a. Method of Disposition	h.A.	20b. Pleca of L	isposition (Nem	ne of		Г	Dec Dete	20c. Location	- City or To	own, State
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ortan Injur	21. Signeture of Funeral Service	DIDENTIFICATION OF THE PARTY OF	Dec			on of Engili					
permit. Pages 1 a Depertment of Her Important: If item any Injury or othe	21. Signeture Puneral Service	0+ 6	1	22. Name em	J Addres	SS OI FACIII	Lee	Funera	al Home	Calve	ert,P.A.
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Physician	Griook, or ribort famore. E	ist only one oddse on ee	or mo.		Λ						Onset end Deeth
/Medical	Immediate Cause (Final	Λ	#		1- 11	e 1		4.			wi off
Examiner	disease or condition resulting in deeth)	a Ha	ule my	ocard	rax	my	arc	1100			Minules
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0 0 0	Pert II. Other significent condi	Itions contributing to dea	th but not resulting in t	he underlying ca	ause give	en in Pert	i.	23b. Dld	tobecco use co	ntribute t	o the cause of death'
by the lach	()							1□	☐ Yes 2☐ No 3 Probably 4☐ Unkno		
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3736									29d. Date signe	ed (Month,	Day, Year)
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withi Tott com		Hehl	of Apath (Item 23a) (T	ype, Print)	016	82	3		12-7	-1999	1
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State	29b. Signeture end title of certi	on Mino completed cause Schlager,	0		DIG	8Z	3 :k,	MD 206	12-7	-)999	1

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** IRELAND JAMES December 15, 1999 10:06 PM /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan. 30,1943 Birthplaca (Stata or Foraign Country) **Funeral** 1 1 2 F Months Days 217-38-4689 Yrs. Director Maryland Usual Rasidence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show hijury or other traumstic event, or Medical Expirior must be nothered 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1921 Ridgeville Road 21037 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 8th Roofer Construction 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) James P. Ireland Elizabeth Irene Rogers 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) James R. Ireland/ Son 1921 Ridgeville Rd. Edgewater, MD 21037
Data 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Ramoval from Stata Mt. Zion U.M. Ch. Cem. 12-18-99 Lothian, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22 Nama and Addrass of Facility
George P. Kalas Funeral Home 21. Signature of Funeral Service Lic 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Acute myocardial infarction Immediata Causa (Final disaasa or condition rasulting in daath) /Medical onehr Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death cartificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Couse (Disease or Injury that initiated avants rasulting in death) Last buriel-tran Dua to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Congestive heart failure 1 Yss 2 No Probably 4 Unknown Division of Vital Records. Certification: To Be Completed by Penplet vescel desia 24b. Wara autopsy findings available prior to completion of cause ol death? 24a. Was en autopsy this cartificate has been 1 ☐ Yas 2 PNo 1 Tyas 2 PTNo To the Hospital or Attending Physician: "within 24 hours after deeth.

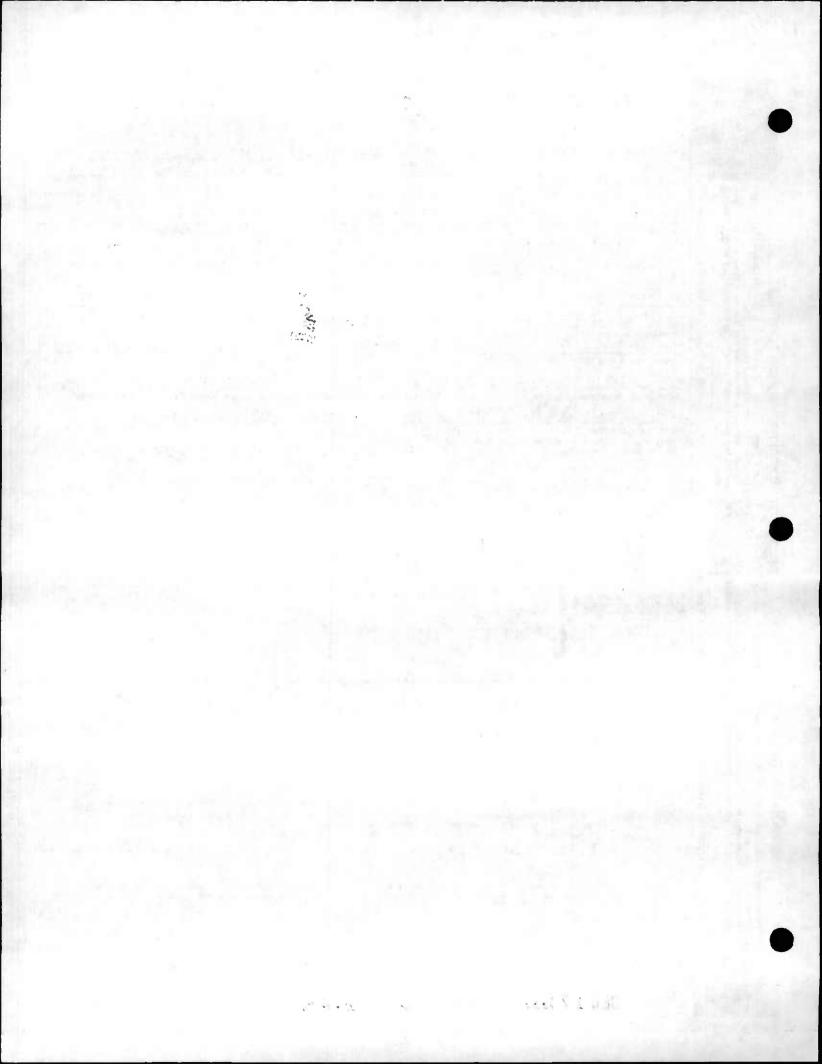
To the Funeral Director: After this cartifica completely filled in by the funeral director; p 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicida 28a. Place of Injury - At home, larm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Cartifier 29b. Signatura end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 123624 Dec 16, 1999 Basant Khandelyal, M.D. 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) South Crain Highway 1600 31. Data liled (Month, Day, Year)
DEC 17 1999 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

socies



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** DECEMBER 8, 1999 23:02 CREINA INNES /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Months Days Hours Min. 12/26/1918 5. Social Security Number 9. Birthplece (Stete or Foreign Country) England 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F 219 04 7440 80 Yrs. Director **Usual Residence of Decedent** with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglans. Important: if Itam 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at each. MD Anne Arundel Annapolis 1 TYes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 1 Ritchie Road 21401 United Kingdom Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Horace Reginald Hatton Iris Christina Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn Sullivan (daughter) 1 Ritchie Road, Annapolis MD 21401 20a. Method of Disposition
1 Durial 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete Metropolitan Crematory 12/11/99 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funéral Service Licenses 22. Name and Address of Facility
Advent Funeral & Cremation Services ▶ MeVille Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory erresf, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical CARDIOGENIC SHOCK 3 DAYS Examiner Due to (or as e consequence of): Examinar ACUTE INFERIOR MYOCARDIAL INFARCTION 3 DAYS attanding physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as e consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION, HYPERCHOLESTEROLEMIA à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy The law 1 Tyes 2 ONo 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred edical Certification: 28c. Injury at Work?

Box 68760. P.O. Records, After this cartificate has funaral director, page 2 Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartiflor completely filled in by the funeral director;

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 THomicide 29a. Certifier

Injury

29b. Signature and title of certified

1 Natural

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

DECEMBER 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TODD PULERWITZ THE JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST. BALTIMORE, MD 21218

RES-000

State Registrar

31. Date filed (Month, Day, Year) DEC 15





088 15 1800 por p. fracts

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Charles Frederick Johnson December 14, 1999 0845 AM 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 610 Beach Drive Annapolis Anne Arundel

Physician /Medical Examiner

	Funeral Director		5. Social Security Number 371 03 3829	6. Sex 1 ☐ M 2 ☐ F		yrs. lest birthday Yrs.) If Unde Months	r 1 Yeer Days	If Undar 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 05/09	rth ay, <i>Year</i>) /1919	9. Bir Co	thplace (Stata or Foraign ountry) th Carolina		
	D		Usual Rasidance of Decedant 10a. Stata 10b. County			c. City, Town or I	ocation				_03/03	71313	bou	10d. Insida City Limits		
	Many Many Median	tor	MD Anne	Arundel		Annapoli	.s							1 ☐ Yas 2 💢 No		
	h with the 23a or 284 at be not	Funeral Director	10e. Street and Number 610 Beach Dri	ve			10f. Zip	Coda				10g. Citizen o	f What Co	puntry?		
020	and 21215-0020 be filed within 72 hours efter deeth with the Maryland tiel hyglene. d other than "natural", or items 23a or 28a-1 show svent, the Medical Examiner must be notified at		11. Marital Status 1 □ Nevar Marriad 2 ☑ Mar 3 □ Widowed 4 □ Divorced	ried 1 Trans	Give	1941- 1945	13. Was Decedant of Hispanic Origin? (Specify If Yas, specify Cuban, Maxicen, Puarto Rical 1 ☐ Yes 2 【XNo Specify:					o- 14. Re Bi	leck, Whit	erican Indian, e, atc. hite		
21215-0020	nari nari	leted by	15. Deceder (Specify only higha	t's Education	-	(Giv	18a. Decedant's Usual Occupation (Giva kind of work dona during most of work lifa. DO NOT usa retired)				ng	16b. Kind of		The state of the s		
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Maryland	should be filed within Mentel Hyglene. merked other than metic event, the M	To Be	17. Fathar's Nama (First, Middle, Frederick J.								. Holm	a, <i>Mald</i> an Su <i>m</i> a es	ıma)			
	2 9 9 9		19a. Informant's Name/Ralations Michael E. Jol		on)							er, City or Tow Arbor				
Baltimore,	00				cematary, cri	natary, crematory or other piece)						ocation - City or Town, Stata				
Balti	permit. Peg Department Important: il any Injury o once.		1 Burial 2 M Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signatura of Funéral Sarvice Licensaa 22. Nama and Addrass of Fecility Advent Funeral & C Annapolis MD 21401 23a. Part 1. Entar tha disaase, or complications that ceused tha daath. Do not antar tha mode of dying, such as cardiec of shock, or heart failura. List only one cause on each line.									Cremation Services				
į	Physician /Medical Examiner		23a. Part1. Entar tha disaase, or shock, or haart failura. List Immediata Causa (Final disaasa or condition rasulting in daath)	complications that only one cause on		daath. Do not an	4 (unc	g, such as o	1401 cardiec c	r raspiratory e	errest,		Approximete Interval Batween Onset and Death		
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ords, P.O. B	y the	y Physician/Medical	Part II. Other significant condition	one contributing to	death but no	t rasulting in tha	undarlying o	eusa giv	an in Part I.		23b. Dld	tobscco use c		to the cause of death?		
		pleted by									24a. Was	sn sutopsy ormed?		Wara autopsy findings svailable prior to complation of causa of daath?		
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	Physician: r this certific rral director,	To Be	25. Was cesa rafarred to medice axaminar? 1 ☐ Yas 2 ☑ No	Hoenitai:	Inneticut	2□ ER/Outpatia	a 2 D	Othi	a.e.		(Check only			24.1		
on of	ding Physin. After this funeral di		27. Manuar of Death 1 Natural 5 Pandin 2 Accident Investig	g 28a. Data (Mo	a of Injury onth, Day Yea	28b. Time		28c. Injury Work	st (? Yes 2 N	2		idance 8 🗆 O how injury occu		city)		
DIVISION	or Attendate deet Director: I in by the	Certification:	3 Suicida 6 Could datarm	not ba	ce of Injury - ding, atc. (Sp	At homa, farm, soecify)	traat, factor				28f. Location (City or To	Straat and Nun wn, Stata)	nber or Ri	urel Routa Number,		
	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	edical C	29a. Cartifiar (Check only one) 1 Certifyin 2 Medical	g Physicisn: To th Examiner: On tha and ma	na best of my basis of axar nnar stated.	knowledga, daa mination and/or l	th occurred nvastigation	at tha tim	a, data and pinlon, daati	piace, e	end dua to tha ed at tha tima,	cause(s) end n data and place	nenner es	s stetad. I to tha causa(s)		
	To th To th comp	Me	29b. Signature and title of contine	eoul	Bu	0		c. Licensa		38		29d. Date sign				
	brig		30. Nama end addrass of parson Stuaut E	who complated call	usa of daath	(Itam 23a) (Type	Print)	700	O Be	stg	ate F	d. A	nna	polis, Mudi		

State Registrar 31. Data filed (Month, Day, Year)
DEC 1 6 1999

PART CONTON

3 Selection Classes

SEC 1 8 1838

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40830 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Dev **Physician** December 16, 1999 MARGARET ANN 12:36 p.m. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yeer If Under 24 Hrs. Hours Min. Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months 1 ☐ M 2 ☑ F Sept 21, 1926 Wyoming Director 368-24-5861 Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 end 2 should be filed within 72 hours effer death with the Marylei Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel; or Items 23a or 28a-f showery Injury or other traumetic event, the Medical Examinal mass by notified as Myersville 1 ☐ Yes 2 ☐ No Frederick Director Maryland 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21773 USA 10323 Clark Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: ρ If Yes, Give Yeer or Dates: 3 Widowed 4 Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government 12 Secretary 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Edward Socia Cora Leone Eldred 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) LouAnn Jarl/daughter 10323 Clark Road, Myersville, Maryland 21773 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 20e. Method of Disposition 1 ☐ Burial 2X Cremetion 3 ☐ Removel from State 12/19/99 Smithsburg, Maryland Smithsburg Crematorium 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Properel Service Licenses 22. Name end Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part Enter the cheese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) in faction /Medical 2 das myocardia Examiner Due to (or as e consequence of) Examiner requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last bunial-tran Due to (or as a consequence of): pue Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of) 98 23b. Did tobecco usa contribute to the cause of death? Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown hypertension signed b by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Yes 2 No 1 Inpatient Certification: To this 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of After Neturel 2 Accident 5 Pending Investigation s efter death. 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 ☐ Homicide To the Hospital o within 24 hours of To the Funerel Di completely filled li Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steled.

2 Medical Exeminer: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29a. Certifier edicai (Check only one) 29b. Someture end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer)

RUSSEL AVE

Decambe 18, 1999

CAITHERSBULC Md. 20F79

State Registrar

30 Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1999

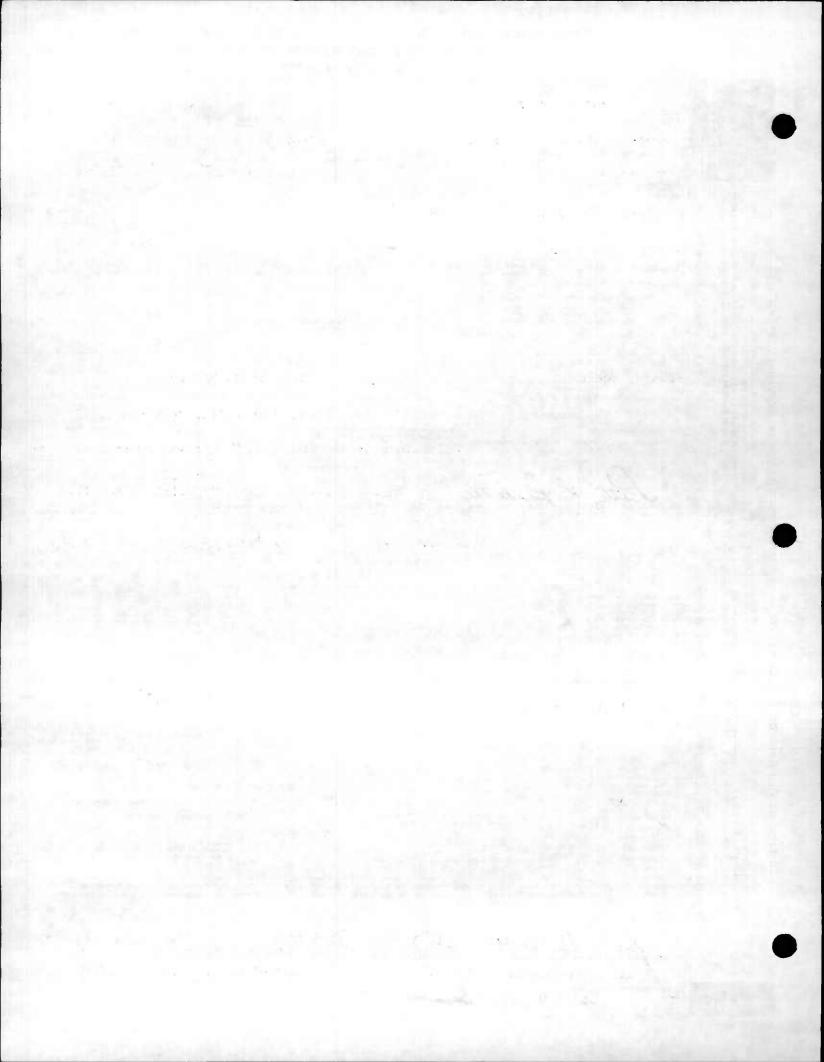
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32. Registrers Signature

MELMICH

R.

gete filed (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Tima of Death December 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 6. Sex 1 M 2□ F 7. Aga (In yrş. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stete or Foraign Country) 216-14-9255 Usual Rasidenca of Decedant Deys Yrs. 10b. County 10c. City, Town or Location 10d. fnside City Limits ANTICOKE Yas 2□No Funeral Director WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1.0 21840 12. Was Dacedent Evar in U,S. Armed Forcas? 1 Yas No If Yas, Give Was Decedent of Hispantc Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Race - Amarican Indian, Black, Whita, etc. 1 Navar Marriad Married 1 Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highast greda complated) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) 17. Falhar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Sumeme) dith nkhown Jones 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Bax Hestey E Jones, Naticoke 20b. Placa of Disposition (Nama of cematary, cramatory or other) 20a. Mathod of Disposition Data 1 Burlal 2 Cramation 3 R 4 Donation 5 Othar (Specify) 3 Ramoval from Stata Bmetex 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Home, ome 23a. Part 1. Enlar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intervel Between Onset and Death fmmediata Ceusa (Final disaese or condition rasulting in daath) Dua to (or as a consequance of): edical Certification: To Be Completed by Physician/Medical Examiner yerros Sequentially list conditions, it any, leading to immadiate causa. Entar Undarlying Cause (Disease or Injury that initieted evants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 Yas 2 No 1 Yas 25. Was casa refarred to medical axaminar? 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 2 ER/Oulpatient 3 DOA 1 Inpatiant 28c. injury at Work? 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred

After this certificate has been To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director,

Funeral

Director

or 28s-f show

234

or items

parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event abos.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0020

216-14-9255

Division of Vital

1 Natural 2 Accident 5 Pending invastigation

6 Could not be datamined 3 Suicide 4 ☐ Homicide

28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Yas 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29b. Signature and arge of certifier

29a, Certifiar

29c. License number

29d. Data signed (Month, Day, Year)

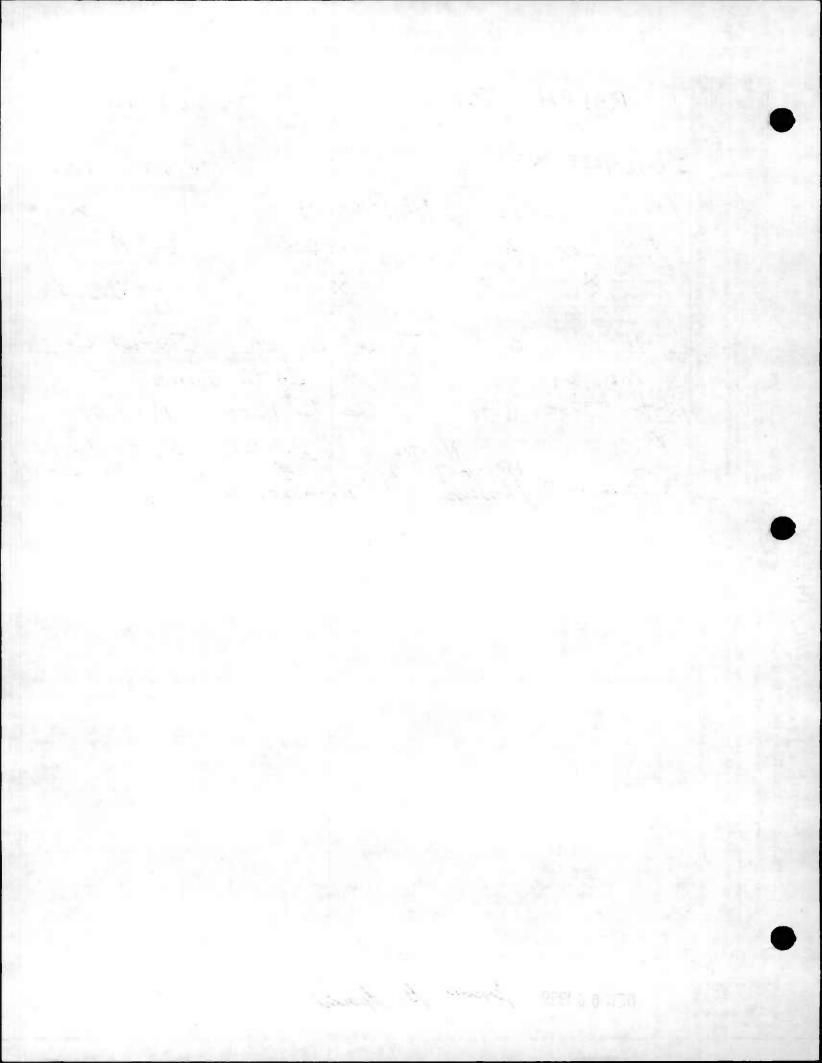
6 State

31. Dala filed (Month, Day, Year) DEC 0 6 1999

30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print)

me Solly mo

Registrar

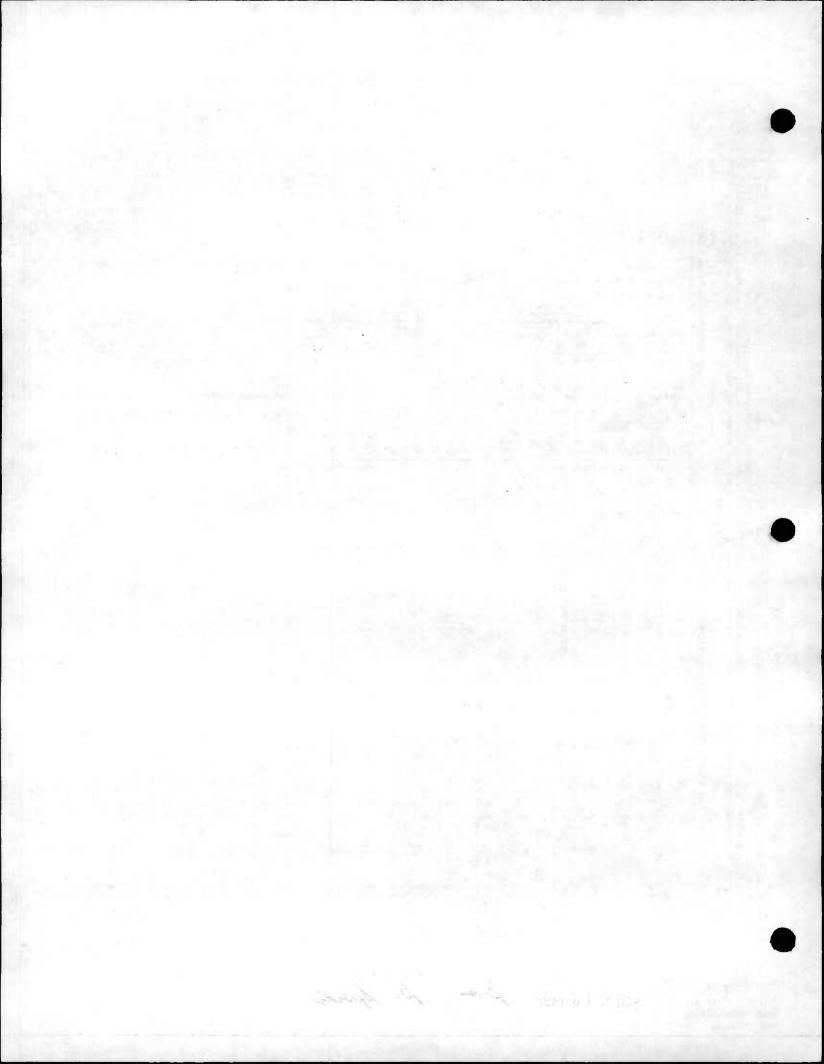


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dh	1. Decedent's Neme (First, Middle, Last)	- 10			2. Dete of Deeth Month	Dey Ye	3. Time of Deeth			
Physician /Medical	VIRGINIA	Ε.	JONES		DECEMBER					
Examiner	4a Fecility Name (If not institution, give street and number	ber)		4b. City, Town, or L		4c. County of D				
	BERLIN NURSING & REHABILI	TATION	CENTER	BERLIN		WORCE	STER			
Funeral	5. Social Security Number 6. Sex 7	. Age (In yrs. las		r If Under 24 Hrs.	8. Date of Birth (Month, Dey, Y		Birthplece (State or Foreig Country)			
Director	221-14-6922 1 M 2 M F Usuel Residence of Decedent	74	Yrs. Months Day	s Hours will.	AUG. 20,	1925 D	ELAWARE			
M M	10a. Stete 10b. County	10c. City,	Town or Location				10d. Inside City Limit			
the Mar 28s-f st cotified ector	MARYLAND WORCESTER	BIS	HOPVILLE				1 ☐ Yes 2 🕅 N			
or 28a-f e notifie Directo	10e. Street and Number		10f. Zip Code		100	. Citizen of Whet	Country?			
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far death of the fame and fame must	11. Meritel Status 12. Was Deced	lent Ever in U.S.		ecify Yes or No-	14. Race - A	merican Indien,				
ir, or he brampa by Fur	1 Never Merried 2 Merried 1 Yes 2 If Yes, Give Year or Det	No No	If Yes, specify Cu		Rican, etc.)	Specify:	vhite, etc. WHITE			
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tal Hy d other event,	17. Father's Neme (First, Middle, Last)			18. Mother's Nem	e (First, Middle, Me					
Menta Menta artice To E	WILLIAM McGIN	INIS		ELSIE	F	HERB				
and ha	19e. tnformant's Neme/Reletionship (Type, Print)		19b. Mailing Address (Street				te, Zip Code)			
27 th	WILLIAM G. JONES/SON		1210 CORAL WA	AY. SINGER	TSLAND.	FLORIDA	33408			
1 Herry officers of the	20e. Method of Disposition	20b. Plac	pe of Disposition (Name of netery, cremetory or other p			c. Location - City				
Page nt: If Iry or	1 X Burial 2 ☐ Cremetion 3 ☐ Removel from St 4 ☐ Donetion 5 ☐ Other (Specify)	EDITM N	CADSET AND							
P. Indiana	21. Signature of Scheral Service Licensee	E	VERGREEN CEME 22. Name end Add		2/13/99 B	EKLIN, M	LAKYLAND			
Dep Impo	1 Chule What	-			ME, SELBY	VILLE, I	DELAWARE 199			
Medical Examiner Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or a	is a consequence of):	n-			8 days			
ficate be physicients the burner edical	Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of):									
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The law requires that the death certicate has been signed by the attending page 2 should be detached for use completed by Physician/M	Sente On	em	en tie	24e. Wes en o		tb. Were autopsy finding aveilable prior to completion of cause of deeth?				
The law te hes lage 2 s					1 ☐ Yes	2 X No	1 ☐ Yes 2 No			
certificate rector, pag	25. Wes case referred to medical			26 Place of Deel	h (Check only one)					
	examiner? 1 Yes 2 No Hospitel: 1 Inc	patient 2 EF	VOutpatient 3□ DOA	Mhoe	ome 5 Resident		Specify)			
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To the Hospital or Attending Phys within 24 hours efter deeth. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To	3 Suicide 6 Could not be	f Injury - At hom , etc. (Specify)	e, ferm, street, fectory, office	9	28f. Location (Stre City or Town,	et and Number o Stete)	Rural Route Number,			
n 24 hours n 24 hours he Funera pletely fille	29a. Certifier (Check only one) 12 Certifying Physician: To the best one)	is of examinetion	edge, death occurred et the n and/or investigation, in my	time, date end plece, opinion, deeth occur	end due to the ceu red at the time, date	se(s) end menne e end plece, end	or es steted. due to the ceuse(s)			
Mithin Mithin	29b. Signature and title of certifier		Licer Licer	nse number	290	I. Dete signed (M	lonth, Day, Year)			
. , , ,	1111	1	1	2026	/	>10	Cela			
	30. Neme end address of person who completed cause	of death /Item 2		2026		210	901			
		Us usatii (item 2	OE/ (TYDO, PORE)				/			
	DR. FEDERICO ARTHES, 46			MD 21011	410 6	41-4400				

DHMH 16 Rav 6/95

Registrar

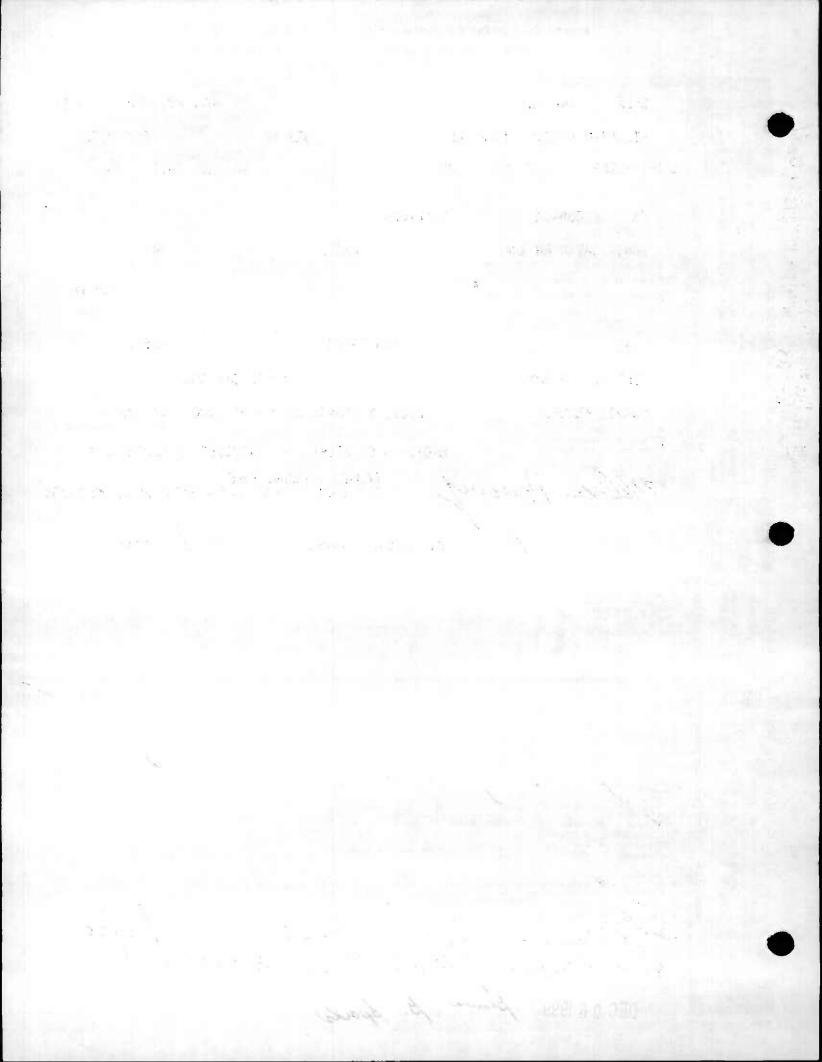


Piease Type or Print in Biack indeiible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** NOV. 29,1999 ELLA KELLEY 0657 /Medical 4b. City. Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER Sap 11-11 29 99 w 565 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 F Yrs 221-16-9283 88 **Director** MAY 26, 1911 VA Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director Department of Health and Mantal Hygiene. Important: or items 23s or 28s-1 inportant: if item 27 is marked other than "natural", or items 23s or 28s-1 in any injury or other traumatic event, the Medical Examinar must be notified any injury or other traumatic event, the Medical Examinar must be notified bytes. VA **ACCOMACK HALLWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 26684 SAVANNAH ROAD 23359 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give X Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: WHITE Specify: Aq 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) nd Mantal Hygiena. marked other than Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Pagas 1 and 2 should be JOHN W. POULSON ETHEL SIMPSON ဂ္ 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) DONNIE KELLEY 26672 SAVANNAH ROAD - HALLWOOD, VA 23359 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Baltimor 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GROTON'S CEMETERY 12/2/99 HALLWOOD, VA 21 Signature of Funeral Service Licenses 22. Name and Address of Fecility **BOUNDS FUNERAL** HOME annu 705 EAST MAIN STREET - SALISBURY, MD 21804 23e. Perv. Enter the disease, or complications that caused which, or heart feilure. List only one ceuse on each light leath. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximete Intervel Between Onset and Death **Physician** ANDION PS WHAT DISTAGES Immediate Cause (Final diseese or condition resulting in death) /Medical THEROSCIENSTIC Examiner Due to (or es a consequence of) Examiner physician and s the burial-transit certificata be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequence of): P.O. Box 68760 Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es a consequence of) usa as id be datached Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peen has 2 ENO 1 ☐ Yes 1 ☐ Yes 2 ☐ No cartificata or Attending Physicien: after death. Director: After this carifica Be 25. Was cese referred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 1 PNatural 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident To the Hospital or Atterwithin 24 hours after des To the Funeral Director complataly filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29d. Date signed (Month, Dey, Year) 29c. License number impleted cause of death (I)om 23e) (Type, Print) 10mul 31. Dete filed (Month, Dey, Year) strar's Signature State Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene q

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MAE JOYCE KIDWELL 9:20 p.m. 1999 December 5 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Mar 25, 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In vrs. lest birthdev) **Funeral** Deys Months Hours 1927 1□M 210 F 72 Yrs. 579 30 3289 Maryland Director Usuel Residence of Decedent death with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Churchton Maryland Anne Arundel 1 ☐ Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street end Number 966 Franklin Manor Road 20733 USA Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumation. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) retail office work secretary 10 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John Minnick Edna Shane 0 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Robert W. Kidwell, Sr. / spouse same as # 10 above 20b. Place of Disposition (Name of cametery, crematory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 N Buriel 2 □ Cremation 3 □ Removel from Stete Southern Memorial Gardens 12-8-99 Dunkirk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licansee. 22. Name and Address of Fecility ton Rausch Funeral Home, P.A., Owings, MD Mam Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Aviedical Immediete Ceuse (Finel ardiac diseese or condition resulting in death) **Examiner** Due to (or es e consequenca of) nobable Myocardial Infarction Examiner physician and s the buriel-transit thet the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical Due to (or es e consequence of) for use es t ed by the a Pert It. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed t should be det Division of Vital Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy s certificate has b firector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpetient 3 | DOA this 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Injury Neturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 29a. Certifier 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Ilyan 23a) (Type, Print) 10 BIVD#703 207 Dun Kirk, MD Town DEC 0 8 32. Registrer's Signeture 31. Date filed (Month, Dey, State 1900 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Deeth DECEMBER 10 1999 1:02 Pm JOHN CHARLES 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 8. Dete of Birth (Month, Dey, Year) Apr. 21, 1914 7. Aga (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1**∑**M 2□F Months Deys Hours 577 07 9258 Yrs. Lowell Usuel Residence of Decedent 10s State 10c. City, Town or Location 10b County 10d. Inside City Limits Prince George's Maryland College Park 1 X Yas 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5918 Bryn Mawr 20740 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yas 2X No Specify: Specify: white 3X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 court stenographer court system 17. Fathar's Nema (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) John F Kelley Comefort Rosemary 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Diana J. Chaney / daughter 3131 Ashwood Drive, Dunkirk, MD 20754 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Resurrection Cemetery 12-13-99 Clinton, MD 21. Signeture of Funaral Sarvice License 22. Name end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death · A unte Myocardial Information Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of): Dua to (or as a consequenca of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown aboble Portarated Viron 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy parformed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 12 Inpatiant 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding 1 Yes 2 No invastigetion 2 Accident

Box 68760. P.O. Records, Division of Vital

Physician

/Medical

Examiner

Director

Funeral

Director

b

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3altimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

Physician

/Medical Examiner

Physician/Medical Examiner anding physician and use as the bunal-transit Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events rasulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Be Completed by or Attending Physician; 25. Was case reterred to medical Certification: To this 27. Menner of Deeth After Neturel e Hospital or Attending 124 hours after death. e Funeral Director; Afte To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 6 Could not be determined 3 ☐ Sulcide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es stated. Medical 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29b. Signeture end title of certifier

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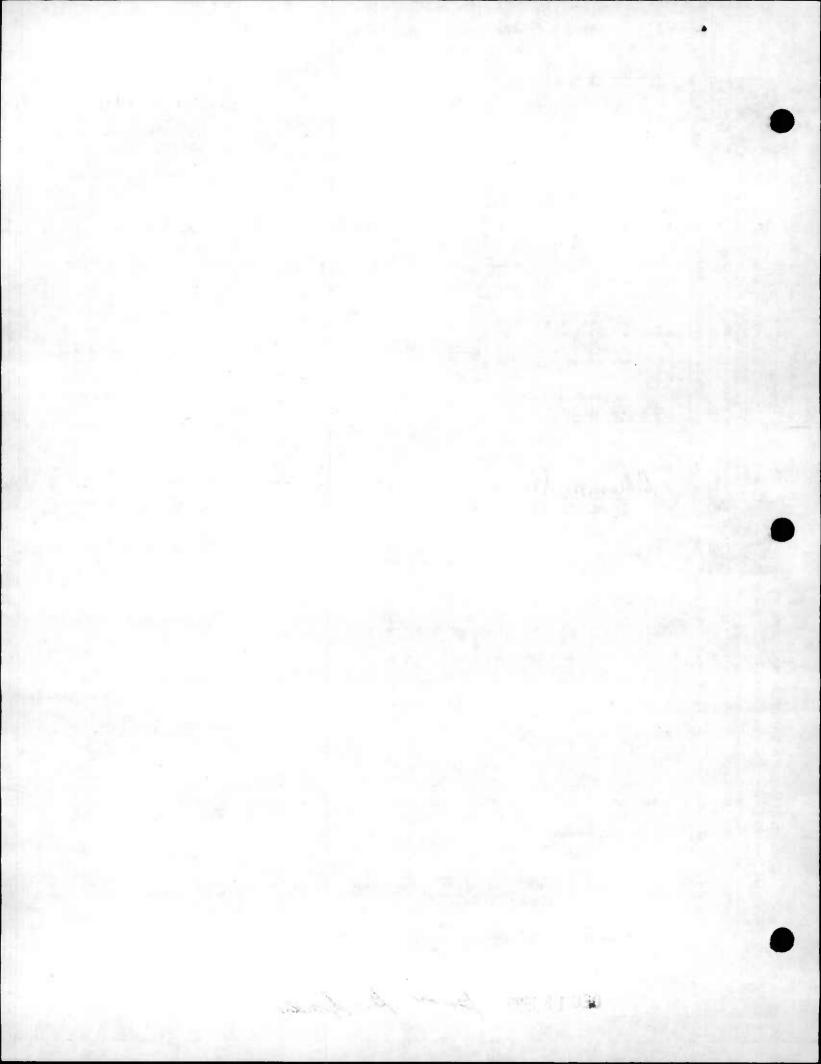
MO D25079 12/10/9 laluld. 30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print) Executive 11. # 502 Leaher Don 12. Yablonowitz, mo roy 31. Dete tiled (Month, Dey, Year) 32. Registreds Signeture

29c. License number

29d. Dete signed (Month, Dey, Year)

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 L 0836

					Certific	ale of	Death		R	eg. No.		
Discolation	1. Decedent's Nama	(First, Middla, Li	est)	West of the				2.	Data of Deal Month	lh Dev	Year	3. Tima of Deelf
Physician /Medical	Robert W	illiam I	OWE	er)			4b. City, To	wn, or Locati	ecembe	14, 1 4c. County	999	2:10pm
Examiner			ward Div				-	Howar		Balti		
Funeral Director	5. Social Security Nu 332–28–3		Sex 7.	Aga (In yrs. last b	irthday) If U Yrs. Mon	nder 1 Yaar Ihs Days		24 Hrs. 8. Min.	8. Data of Birth 9. Birthplaca (State			
	Usuel Residence of I	Decedent						123	OI 22,	1932		HOIS
Haden feder tor		Vermi	lion		m or Location						10	d. Inside City Lim 1X□ Yas 2□
r 28a-f ahow Indiffed at	10e. Street and Num	iber				Zip Code		1	1	0g. Citizen of W	hat Count	ry?
r items 23s or 28s-f and the most be notified. Funeral Director	1106 Nor	th Gilbe	rt Street			61	832			USA		
items 23 mer must	11. Maritat Status	EV III	12. Was Decede Armed Force	nt Evar in U.S.	13. Wes D			gin? (Specify	Yes or No-	14. Race	- Amarica	
by By	3 ☐ Widowed 4		11 Yas 2			s 2XI No		, rueno nic	an, etc.)	Specify:		White
ygiene. The tradical Examinate, by the tradical Examinate. Completed by Fu	(Specification (Speci	15. Decedent's E ify only highest grandary (0-12)			a. Decedent's (Giva kind o lifa. DO NO KNOWN	Jsuel Occup I work done IT use retire	pation during most d)	t of working	ι	16b. Kind of Bu INKNOWN	siness/Ind	ustry
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I Health and Mental Hygien ten 27 le marked other the other traumatic event, the	John Ber										a <i>)</i>	
De a	19a. Informant's Nar		(Type, Print)	19	b. Mailing Add	rass (Street	and Numbe	er or Rural R	outa Number	, City or Town,	Stata, Zip	Code)
of Health If Nem 27 I or other tra	Melissa 1	Lowe /	niece		1137 S	unris	e Beac	h Road	d. Cro	Wnsvill 20c. Location -	e. MT	21032
H P P P P P P P P P P P P P P P P P P P	20a. Mathod of Dispo		WO	comet	of Disposition ary, crematory	(Nama of or other pla	ce)	Dec	20	20c. Location -	City or Tov	m, Steta
		5 ☐ Other (Speci	ARemoval from Sta		Columba	Ceme	terv		999	Ottawa,	Illi	nois
Department Important any Injury ance.	21. Signature of Fun	neral service Lice	nu64 / 1	/	28 Nam	a and Addre	ess of Facilit	у		erna Pai		
hysician Medical	23 Parti. Enter the shock, or heart Immediate Cause (F diseasa or condition	Finel	V	anous Cel					spiratory arr	Severna ast,	1	Approximate interval Between Onset end Death
m end rial-transit Examiner	rasulting in death) Sequentially list con if any, leading to imp	editions,	b	Dua to (or as a	i consequence	of):						
ing physicia a as the bur Medical	Cause (Disease or in that initiated events resulting in death) La	fying njury ast	d	Dua to (or as a	consequence	of):					1	
od for	Part II. Other signific	cant conditions	contributing to dealf	but not rasulting	in tha underly	ng causa gi	ven in Part I		23b. Did to	obacco use con	tribute to	the cause of de
d by the attend letached for us Physician	Car	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause g CAD, Ilypertension							1 Yes 2 No 3 Probably			
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certificate has b rector, page 2 a	25. Was casa referre examiner? 1 Yes 2 A 27. Manper of Death 1 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only	5 Pending invastigatio 6 Could not be detarmined	28a. Place of building,	Injury 28b. Injury - At homa, etc. (Specify) st of my knowleds of axaminetion a	Tima of Injury M arm, street, fa	28c. Inju	her: 4 Number Nu	No 28f.	perion 1 in Y. Check only or 5 Rasida Describe har Location (S. City or Town due to the cat the time, d	as 2 No ne) ence 6 Other ow injury occurr treet and Numb n, State) ause(s) and me	ava con of c	lable prior to pupelion of cause eath? Yas 2 No Pouta Number, ated. the cause(s)
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in 24 hours efter death. • Funeral Director: After this certificate has be pletely filled in by the funeral director, page 2 stellers! To Be Compleed call Certification: To Be Comple	25. Was casa referre examiner? 1 Yes	Pending invastigation of Could not be detarmined. Cortifying Pt Medical Examination of Cortifier Cortifier	28a. Data of Information (Month), in the 28a. Place of building, in the 28a. Place of buildin	Injury - At homa, etc. (Specify) st of my knowleds of axaminetion a steled.	Tima of Injury M M iarm, street, fa je, death occur nd/or Invastigs	28c. Inju Wo 1 ctory, office	her: 4 Number Nu	No 28f. d place, and th occurred a	perion 1 in Y. Check only or 5 Rasida Describe har Location (S. City or Town due to the cat the time, d	as 2 No	ava con of c	lable prior to poletion of cause eath? Yas 2 No Pouta Number, ated. the cause(s)
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TEC 1 7 1999 Proses D. Arrida

Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December Lester A. Levine 13, 1999 7:00 am /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 704 Faircastle Avenue Severna Park Anne Arundel If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1⊠ M 2□ F Yrs. 82 Director 040-14-6362 Jan 19, 1917 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits raif, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Faircastle Avenue 21146 death Funeral USA 12. Wes Decedent Ever in U.S. Armed Forces?

120 Yes 2 No
If Yes, Give 1941 —
Yeer or Detes: 1976 Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Raca - American Indien permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or item any injury or other traumatic event, tre Medical and MES. Black, White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 28 No Specify Specify. White P 3₺ Widowed 4 Divorced 1970 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Wetlands Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Not Available Not Available 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Leslie Schneider / daughter 1006 Placid Court, Arnold, MD 21012 20b. Plece of Disposition (Name of cametery, cremetory or other plece, 20e. Method of Disposition Dec. 20c. Location - City or Town, Stete 1 DxBuriel 2 Cremetion 3 Removel from State Arlington National Cem. Arlington, VA 4 ☐ Donetion 5 ☐ Other (Specify) 1999 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral 21. Signety of Funerel Service Licanse 495 Gov. Ritchie Hwy., Severna Park, MD 21146 nanco 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician and the bunal-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. been signe should be by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior fo completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation ne Hospital or Attending in 24 hours after death. the Funeral Director: Afte pletely filled in by the fun 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. Medicai 29a. Certifier within 24 hor To the Fune completely fi (Check only one) To the 29b/Signeture end title 29d. Date signed (Month, Day, Year) 120 ANNAPOUR 31. Date filed (Month, Day, Year) 32. Redistrer's Signeture State 1 DEC 5 1999 Registrar

DEC 1 5 7945

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Stephen Edward Linger 17,1999 December 6:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 4, 1918 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex **Funeral** 1 M 2□ F Months Hours 398-03-9305 Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 6 256 Carroll Parkway 21701 U.S.A. 234 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II Race - American Indian, Black, White, etc. natural, or items 11 Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hydiene. Important: If item 27 la marked other than "natural", or iten eny injury or other treumatic event, the Matrice Exercises page. 1 Never Manied 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Heavy Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mary Effie Carter John Curry Linger 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 256 Carroll Parkway, Frederick, Maryland Mrs. Juanita S. Linger, wife 20b. Placa of Disposition (Name of cametery, crematory or other place) Resthaven Memorial Gardens, Dec. 24, 1999 Frederick, Md. 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanse 22. Name and Address of Fecility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Pseudomonas Examiner Be Completed by Physician/Medical Examiner spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Multiple C Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown cardiamyopathy Evit 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate hes Hypertension 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To this

Attending Physician: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attendi within 24 hours after deeth To the Funeral Director: A completely filled in by the fi

Saltimore, Maryland 21215-0020

CM 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 300 w 9th st. Frederick, md 21701 WID 31. Date filed (Month, Day, Year) DEC 2 0 1999 32. Registra s Signeture State Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28a. Date of Injury (Month, Day Year)

illed in by the funeral

After

deeth.

27. Menner of Death

1 Natural

2 Accident 3 Suicide

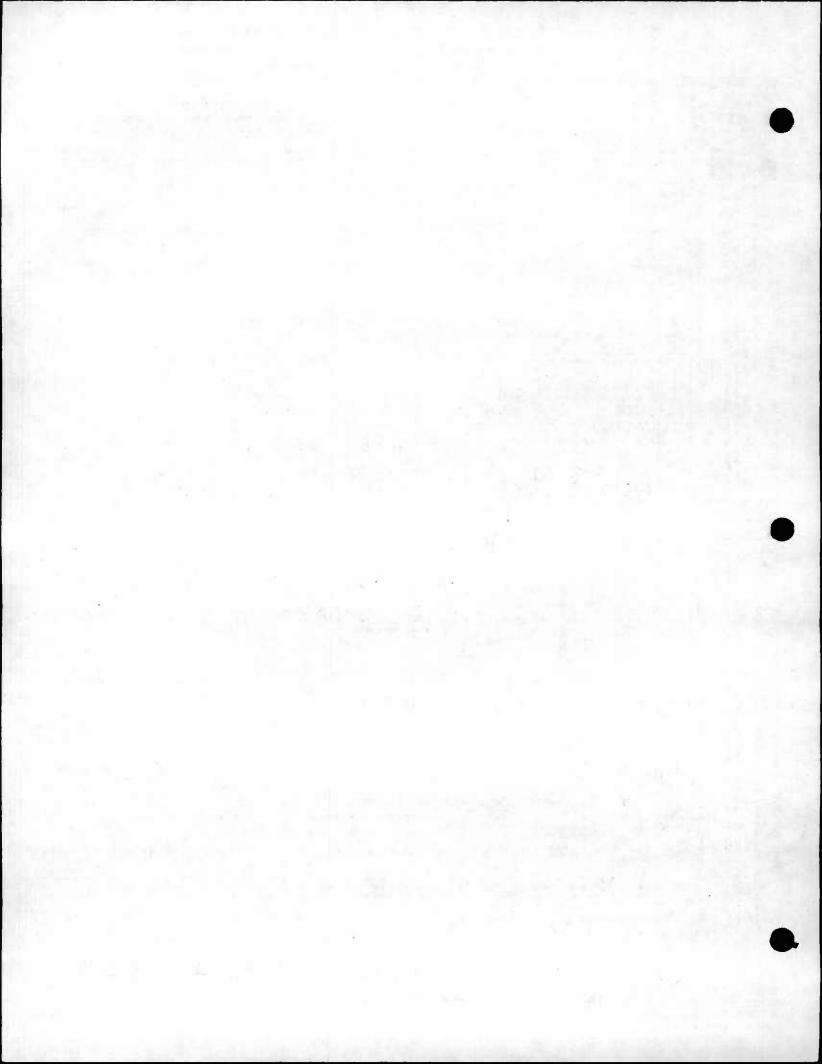
4 ☐ Homicide

29b. Signature and title of certification

29e. Certifier

5 Pending investigation

6 Could not be



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician HERMUS** WILLIAM LOWE Jecomber 1999 3 2153 /Medical 4b. City, Town, or Location of Death SALISBURY 4e Facility Name (If not institution, give street end number) 4c. County of Death WICOMICO Examiner PENINSULA REGIONAL MEDICAL CENTER 8. Data of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Days Months Hours 1₽M 2□F 221-07-2363 85 Yrs. July 12,1914 Delaware Usuel Residence of Decedeni 10a Siete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1868 South Division St. 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Yaar or Datas: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Restaurant Owner Food 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Meredith Lowe Addie Florence Davis 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha S. Lowe/Wife 1868 S. Division St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Springhill Memory Gardens 12/7/99 Hebron, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funerel Service Lice 501 Snow Hill Rd., Salisbury, MD 21804 never 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediete Cause (Final disease or condition resulting in deeth) ASCUD Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, laading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): that initieted events resulting in death) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 SNo 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 CER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed ettending physicien and for use as the buriel-tran-P.O. Records. pege 2 should certificate of Vital f or Attanding Physician: after death. Diractor: After this certifica director, Division

Funeral

Director

ahow

Hygiene. other than "natural", or hama 23a or rant, the Medical Examiner must be

i. Peges 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Itam 27 is marked other ti jury or other traumstic avant, to

parmit. Peges:
Department of H
Important: If Its
any injury or ot
once.

Physician

/Medical

Examiner

21215-0020

Baltimore, Maryland

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LOWE

Fermus W.

Certification: To filled in by

29a. Cartifiar 29b. Signeture and titla of certifier

4 ☐ Homicide

1💯 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted.

29c. License number 45049)

29d. Date signed (Month, Day, Year) 12/5/99

30. Name end address of person who completed causa of daeth (Item 23a) (Type, Print)

Dr. Christopher Snyder 106 MilFord St. Swite 201, Salisburg Md. 21801 31. Dete filed (Month, Day, Year) . Registrer's Signeture

State Registrar

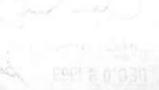
Medical

DEC 0 6 1999

A Hospital

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within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month November 23, 1999 Phillio Lombardo, 10:10 PM 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Salisbury Center: Genesis ElderCare Salisbury, MD Wiconico 5. Social Security Number If Undar 1 Year | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 6. Sex 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 11 M 2□ F Days Hours Yrs. 222-05-4905 Usual Rasidence of Decedent February 7,1912 New York 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 200 Civic Ave. 21804 IISA 12. Was Decedent Ever in U.S. Armed Forcas? 1 ⊠ Yas 2 □ No Arm If Yes, Giva Yaar or Datas: WW I 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status Race - American Indian, Black, White, etc. Army 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 → Widowed 4 Divorced White WW II 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Traffice Light Division City of Salisbury 8 17. Father's Nama (First, Middle Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Salvatore Lombardo Salvatrice 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Phillip J. Lombardo Jr./Son 5 Emerson Lane, Granby, CT 06035 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal Irom Stata 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 11/26/99 Salisbury, MD Funeral Service Licensee 22. Nama and Addrass of Facility moiosi Holloway Funeral Home Professional Association arrie B Compon 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) erezona Dua to (or as a consequence of): man Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last due to (or as a consequanca of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown an 4219 dixerel 24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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10a. Stata

Funeral

Director

8 must b

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pas 1 and 2 should be fill of Health and Mental H if item 27 is marked off or other traumatic even

Department of important: If it any injury or o

filed within 72 hours after

Maryland 21215-0020

Saltimore, Pages 1 a

inding physician and use as the burial-transit

The law requires that the death certificate be axecuted

Box 68760.

P.O.

Records,

Division of Vital

Physician/Medical Examiner à Be Completed

2 al or Attending Physician: The state death.

In Director: After this certificate of in by the funeral director, pa Certification: To

has certificata

24 hours To the Hospi within 24 hou To the Funer completely fil edical VA + 8 State

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Hospital

25. Was casa refarred to medical axaminar? 1 ☐ Yas 2 No 27. Manner of Death 1 HNatural 2 Accident 3 Suicide 4 Homicida

29a. Cartifier

(Check only one) 29b. Signatura and titla of certified

31. Data filed (Month, Day, Year)

NOV 3 0 1999

5 Pending investigation

6 Could not be detarmined

1 Scrifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28a. Data of Injury (Month, Day Year)

32. Registrar's Signatura,

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify)

28b. Tima of

1104 Healthway Dr., Salisbury, MD

souls!

D 29349

29c. Licensa number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

21804

28l. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Othar: 42 Nursing Homa 5 Rasidence 6 Othar (Specify)

28d. Dascribe how injury occurred

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) William H. Robins, M.D.

DHMH 16 Rev 6/95

Registrar

1 2 20 20 2 0 2 VGH

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State of Maryland / Department of Health and Mental Hygiene

tale of			Ce	ertifica	te of Death	ל	Reg	. No. 9 9	4	0841		
Physician	Decedent's Name (First, Middle,	Last)					ate of Death lonth	Day	Year	3. Time of Death		
/Medical	BRANDY LYNN 4a Facility Name (If not institution,		LEWIS		4b. City. T	own, or Location	ecember	4c. County	1999	09:37 AM		
Examiner		Regional Hos	nital Cen	tor		alisbury			comic			
Funeral		S. Sex 7. Age	(In yrs. last birthday		or 1 Year If Unde	or 24 Hrs. 8 D	ate of Birth		9. Birthpla	ace (State or Foreign		
Director	213-90-7657	1□M 2Å F	22 Yrs.	I WORKER	Days	MA	onth, Day, Y	977	MAR	ace (State or Foreign YLAND		
Jend Mend	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10	d. Inside City Limits		
ours after deeth with the Maryland rail; or items 23a or 28a-f ahow Examiner must be notified at 1 by Furneral Director	MARYLAND WICOM	ICO	SALIS	BURY						1 ☐ Yes 2 No		
n or 28a-f a be notified	10e. Street and Number			10f. Zi	p Code		100	. Citizen of V	What Countr	ry?		
w the	31294 DOGHOUSE				21804			J.S.A.				
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within 72 hours after ene. then "netural", or fu the Use Energy empleted by Fu	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes	2 No Specify	r.		Specify	IITE			
led within 72 ho byglene. Nor then "naturn it, one then cell Completed	15. Decedent's (Specify only highest		16a. Dec	edent's Usu e kind of w	ual Occupation	est of working	16	b. Kind of Bu	usiness/Indu	ustry		
HDI CON	Elementary/Secondary (0-12)	College (1-4or 5+			ork done during mo	or or working		OFA	ECOP.	60) (D 1) W		
Hygle Hygle off. ID off.	17. Father's Name (First, Middle, L	net)	A5515	IANT	MANAGER 18 Moth	ner's Name (Firs	Middle Ma			COMPANY		
Mentel H Mentel H irked off ide ever	DENNIS ARNOLD	LOKEY				THY A.			10)			
s and Mentel e marked eumatic ev	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mai	ling Addres	s (Street and Numl	ber or Rural Rou	te Number, C	City or Town,	State, Zip C	Code)		
and 2 saith a 7 27 le or tre	DENNIS A. LOKEY	- FATHER	3129	4 DOG	HOUSE DR.	. SAL]	SBURY	MD 2	1804			
Pages 1 and 2 should be filed within inent of Health and Montel Hyglene. mt: If them 27 le merked other than int or other treumadic event, tre 14 To be Comp	20a. Method of Disposition 1 Di Burial 2 Deremation 3	□ Removet from State	20b. Place of Disp cemetery, cre	osition (Na ematory or	me of other place)	Da	e 20	c. Location -	City or Tow	m, State		
Part V	4 □ Donation 5 □ Other (Spe	cify)	GREENBAC	KVILL	E CHURCH	CEM. 12	15/99	STOC	KTON,	MD		
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rificate be executed ing physician and set the burlat-transit Medical Examiner												
E 6. 3												
deeth od for sicia	Part If. Other significant condition	Ignificant conditions contributing to death but not resulting in the underlying cause given in Part f.							23b. Did tobacco use contribute to the cause of death			
The law requires that the deeth ca ta has been signed by the attendi page 2 ahouid be detached for use completed by Physiclan/		-ек п. Опис эндиписани солишиота contributing to death but not resulting in the underlying cause given in Part f.							1 Yes 2 No 3 Probably 4 1nknow			
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	Of Was and other day of the						1 XYes	2□ No	1/2	Yes 2□ No		
ysician: The I is certificate he director, page To Be Com	25. Was case referred to medical axaminer? 1 X Yes 2 No	Hospitat:	2 XER/Outpatie	a 2 D	Other:	ce of Death (Che		- 6 🗆 🗆	(C:4-:1			
5 5 5	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		-	28c. fnjury at Work?	lursing Home : 28d. [escribe how					
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tal or Attending Presents after death. el Director: After tiled in by the funera Certification:	3 Suicide 6 Could no 4 Homicide determin		/ - At home, farm, si	treet, factor	ry, office	28f. L	81. Location (Street and Number or Rural Route Number, City or Town, State) R+113					
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n 24 hound	(Check only 2 Medical E)	Physician: To the best of arminer: On the basis of e	xamination and/or in	th occurred	at the time, date a	and place, and death occurred at	ne to the caus the time, date	se(s) and ma and place,	nner as sta and due to t	ited. the cause(s)		
To the Hospital or A within 24 hours after To the Funerei Direct Completely filled in by Medical Certifi	29b. Signature and title of certifier	and manner state	a.		c. License number			. Date signe				
F 3 F 8	A Change (Chut				F						
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				Certifi	cate of D	<i>Jeath</i>	R	eg. No.	70076		
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Physician /Medical	SEAW	PATRIC	14	MUZ	6H1			3-19-	19 17=36 Hrs		
Examiner	4a Facility Name (If not Institution, g	rive street end number)			4b	o. City, Town, or	Location of Death	4c. County	of Deeth		
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uneral rector	5. Sociel Sacurity Number 6. 212–96–9433 Usual Residence of Decedent	. Sex 7. Ag	e (In yrs. lest t		Inder 1 Year onths Deys	If Under 24 Hrs Hours Min.		7, 1975	Birthplace (State or Foreign Country) Maryland		
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A notifie Directo	10e. Street end Number	arioru			of. Zip Code		1	0g. Citizen of W	/haf Country?		
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To	Michael X. Murp	hy				Cath	erine Kai	rwacki	5-5-111		
any Injury or other traumatic event, tre. M. once. To Be Comp.	19e. Informant's Name/Reletionship	(Type, Print)	nd Number or Ri	urel Route Number	r, City or Town,	Stete, Zip Code)					
	Catherine Murph	y (Mother)	1	36 Law	Street	, Aberd	een, Mary	yland 2	21001		
6	20a. Method of Disposition		20b. Place cemer	of Disposition	(Neme of y or other place)	Date	20c. Location -	City or Town, State		
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any Injury	21. Signature of Funeral Service Lice	ensee /		22. Nar	ne end Address	s of Facility					
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rtification	3 Suicide 6 ☐ Could not determined		LAGE		OME		MULLA		1687		
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npietely filled in by the funer dedical Certification :	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Exe	Physician: To the best	examinetion e		ation, in my opi	inion, death occu	urred et the time, d		and due to the cause(s)		
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DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 11 1999 9:10 PM Thomas Marshall Jr. Dec · /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Talbot Easton The Pines Genesis ElderCare -If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Ye 4-02-16 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 M 2 □ F Yrs Director 83 Maryland 220-10-6173 Usual Residence of Decedent the Marylend 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits lem 27 is marked other than "naturel", or ferms 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at 1 Yes 2□No Director Michaels Talbot 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 21663 101 Miles U.S. Lane Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Detas: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced permit. Peges 1 and 2 should be filed within 72 hour Department of Health and Mentel Hygiene. Important: if Item 27 is marked... any injury or other contract. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) WATERMAN Sen Food 6 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumema) Be Marshall Annie Thomas Marshall Sr. 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lane St. Michaels, Md. 21663 101 Miles Marshall (wife) Cleo 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □Ramoval from State St. Michaels, Md. 12/18/99 Thomas Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses 322 East Ave. Dashiell Funeral Service Easton, Md 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) HATERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Examiner CIENSIVE certificate be executed -trens Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest end Due to (or es e consequence of) physiclan e s the buriel-P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 use foru ed by the e Part II. Other algrificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY signed b Records, by 24b. Were eutopsy findings evallable prior to complation of causa of deeth? Completed CHRONIC OBSTRUCTIVE PUMONARY 24e. Was en eutopsy peen hes page 2 certificate 1 Tyes 2 TONO 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medical axeminer? director, Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred i or Attending P sefter death. I Director: After t Certification: 5 Pending investigation 1 Netural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atten within 24 hours efter dea To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) end manner stated. 29a, Cartifian Medical 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 30. Neme and eddress of person who pletad cause of deeth (Item 23a) (Type, Print) BREMER MD 800

State Registrar

31. Dete filed (Month, Day, Year)

DEC 1 4 1999

32. Registrer's Signeture

Depera

Thomas

Salah Managaran Managaran

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1150 ALBERT EDWARD MOSER December 14 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1₩ 2□ F Yrs. 88 217-10-9092 Sept 10, 1911 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21742 11618 Pheasant Trail Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yas, Giva Year or Dates: 1930-33 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Married 2 N Married 1□ Yas 2√ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Mechanic Auto 10 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Della M. Marker George E. Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 11618 Pheasant Trail, Hagerstown, MD 21742 Elsie Moser/spouse 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Mt.Zion U.Methodist Cemt 12-18-99 Myersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fe 22, Name and Address of Facility 504 Main Street Myersville, MD 21773 Ricketts Funeral Home Approximata Intarval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, one cause on each line. Immediate Cause (Final diseasa or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Que to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? STHMATIC BRONCHIT 1 Yes 2 10 10 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 Yes 2 JH6 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending 1 TYes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760. P.O. of Vital Records. Physician: Attending ŏ Hospital

Funeral

Director

show notified at

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Department of P Important: If he any Injury or of

Physician

/Medical Examiner

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page 2

4 ☐ Homicide

29a. Certifier

29b. Signatury

(Check on one)

certificate

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death.

within 24 hours after deal To the Funeral Director:

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death with

filed within 72 hours after

21215-0020

Maryland

Baltimore,

State Registrar

DHMH 16 Rev 6/95

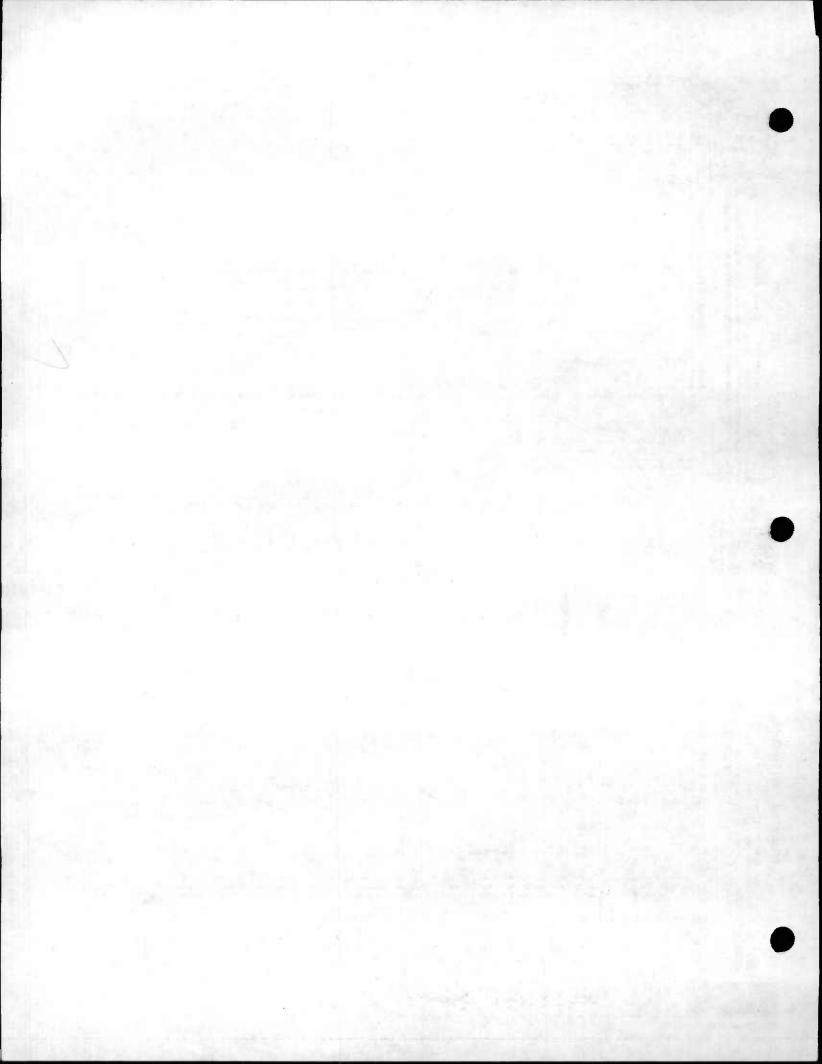
32. Registrary

1999

Stiffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

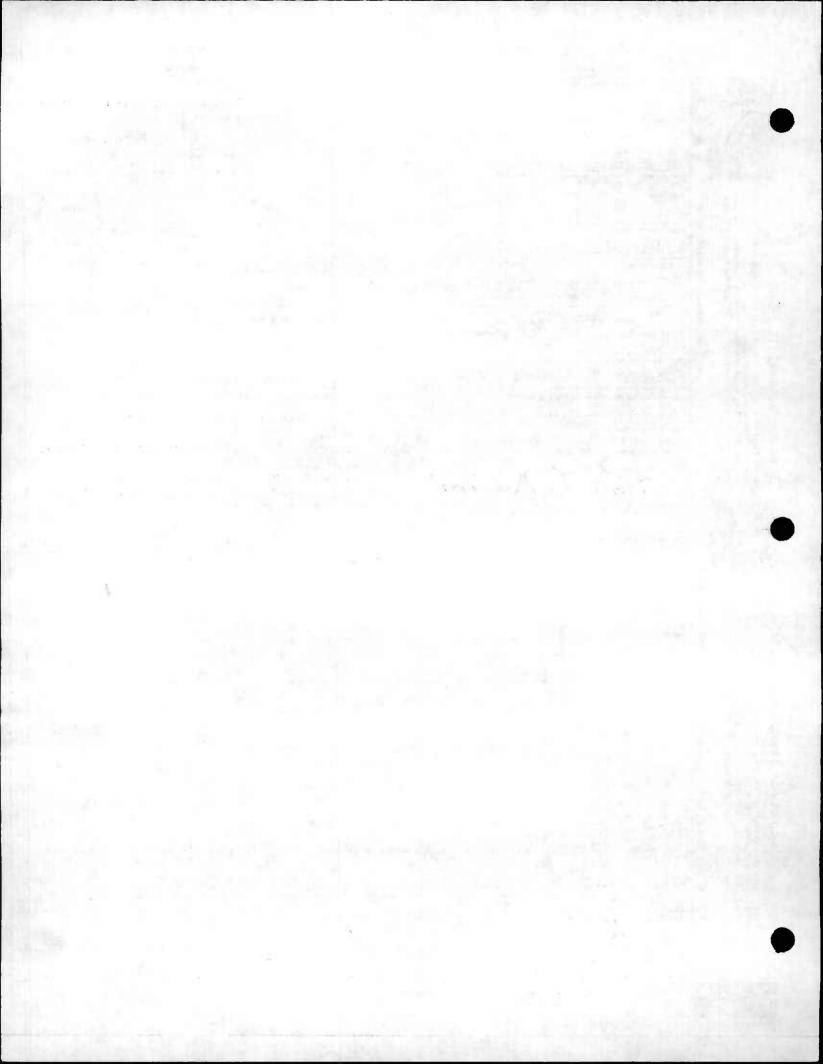
29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

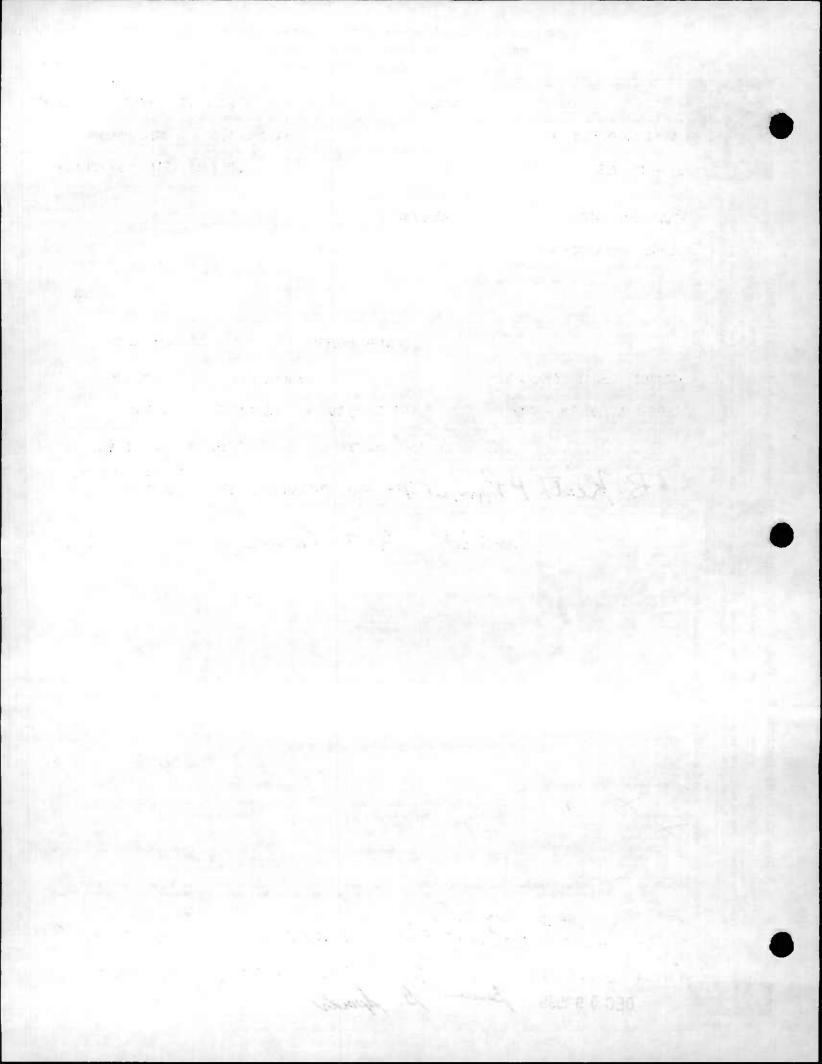
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/Medical Examiner	4a Facility Nama (If not institution, giva	street and number)			4b. City, Town, or		4c. County of			
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Funeral	Social Sacurity Number 6. Sec.		(In yrs. last birthday)	If Under 1 Yaar Months Days		8. Dete of Birth (Month, Day		9. Birthplace (State or Foreign Country)		
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and lagith m 27 her tr	Karen Rice - Nieco	e			Drive, D					
permit. Pages 1 ar Department of Haa moortant: If Item Iny Injury or other Ince.	20a. Method of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ F	Removal from Stete		netory or other ple			20c. Location - Ci			
Pant:	4 Donation 5 Other (Specify)		Alleghe	ny Cemeto	ery	12/15/99	Pittsbu	rgh, Penna.		
permit. Depart Import eny inj	21. Signature of Funaral Service Licensee 22. Nama and Address of Facility Olin L. Molesworth P.A., Funeral Home									
80599	Tourt L.	Nellias			ge Road,					
	23a. Part 1. Enter tha disease, or compl	ications that caused th	ne deeth. Do not ent	er tha mode of dy	ing, such es cardiad	or respiratory arr	est,	Approximata		
Physician	shock, or heart failure. List only or	na ceusa on aach ima.						Interval Between Onset and Death		
/Medical	Immediata Causa (Final disaasa or condition	BPI	EAST	CANCE	ED - ME	TA-STA	LTIC	6 MONTHS		
Examiner	rasulting in death)			AST CANCER - METASTATIC 6 MONTH (or as a consequence of):						
ةِ تِ		10,74,71								
tificate be executed go physicien end as the buriel-transit	Sequentially list conditions.)	ue to (or as a consec	uence of):						
EX Line	Sequentially list conditions, it any, laading to immadiata causa. Enter Underlying Cause (Diseese or Injury									
ficata be expression as the burie	that initiated evants resulting in death) Last	Dua to (or as a consequence of):								
- P										
attendin for use		d								
the death cer d by the attendir eteched for use	Part II. Other significant conditions con	ntributing to death but	not rasulting In tha u	nderlying cause gi	iven in Part I.	23b. Did to	obacco use contr	ibute to the cause of death?		
of the de etached					1 U Y	1 Yes 2 No 3 Probably 4 Unit				
The law requires thet the death certain the has been signed by the attending page 2 should be detached for use Completed by Physician/A						24a. Was a perform		24b. Were eutopsy findings available prior to		
law re la				_				completion of cause of death?		
The law sate has page 2						1 U Y	es 2 No	1 ☐ Yes 2 No		
certificate rector, pag	25. Was case ratarred to medical				26. Place of Dea	ath (Check only or	na)			
	examiner?	lospitel:	2 ER/Outpatier	t 3 DOA Ot	har .	loma 5 ☐ Rasid		(Specify)		
erthis heral d	27. Mannar of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Tima of tnjury	28c. Inju	iry at	28d. Describe h	ow injury occurred	1		
Attending For death. octor: After by the funer iffication:	1 Accidant 5 Panding invastigation	(Monan, Day)	M 1							
or Attending after death. Director: After I in by the fune ertification	3 Suicide 6 Could not be datarmined	28a. Placa of Injury building, atc. (- At home, farm, str	eet, factory, office	281. Location (Street and Number or Rural Routa Number, City or Town, State)					
3 5 2 9 O		Jones Ig. atc. (3.7 3.1 3.11				
Hospital 24 hours of Funeral staly filled	29a. Cartifiar 1 Cartifying Phys	sician: To the best of r	my knowledge, death	occurred at tha ti	ima, date and place	, and due to the c	ause(s) and mann	nar as stated.		
he Hospi in 24 hou he Funer pletaly fill	one) Medicat Examin	ner: On the basis of ex and menner stete	id.	restigation, in my	opinion, death occu	rreo at trie tima, o	are and place, an	u due to the cause(s)		
within Z To the comple	29b. Signature and atterol cartifiar				se number	2	9d. Date signed ((Month, Day, Year)		
	> College			DI	28656		Decembe	r 13,1999		
	30. Nama and address of person who co	mplated causa of dea	th (Item 23a) (Type,	Print)		1 1 1 1 1				
	Ravi Passi M.D. 86	509 2nd Ave	enue Suite	404B S1	liver Spr	ing. Mary	vland			
State	31. Data filed (Month, Depter) 1 4	1000 Registra	Signature							
Registrar	DEU 1 4	יין ב כטכוי	,	10. 16	parke					

DHMH 16 Rev 6/95



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				State o	of Marylan		artmen ertificat				lental Hyg	iene 9 9	l li	0847		
		Decedent's Neme (First, Middle, Last)									2. Dete of Deet	1	Yeer	3. Time of Deeth		
Physician /Medical		IDA	BELLE		MOO	RE					DECEMBER 7,199		9	4:55 AM		
AT.	Examiner	4a Facility Neme (If not If		street end nu	imber)			4			cation of Deeth	4c. County				
		6341 OXBRID 5. Social Security Number			7. Age (In yrs.	last hirthday) If Under	1 Year		ALISE			MICC			
	Funeral Director	214-10-9275		_M 2KJF	81	Yrs.	Months	Deys	Hours	Min.	8. Date of Birth (Month, Dey, JULY 19	,1918	MAF	plece (Stete or Foreign ntry) RYLAND		
		Usual Residence of Dece			1.0											
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ad S	or 28a-f s be notified	MARYLAND W] 10e. Street end Number	COMICO		SA	LISBUE	101. Zip	Code			10	Og. Citizen of V	Vhet Cou			
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20	er, or the	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ D		If Yes, G			1 ☐ Yes		Specify.			Specify		WHITE		
00-	"natural", or soins Exam leted by F		Pecedent's Edi	Year or E	Detes:	16e Dece	edent's Lisur	ei Occupi	etion			16b. Kind of Bu				
215 215	Medic plet	(Specify onl	ly highest gred	de completed) Coilege ((Giv.	 Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired) 				ing	TOD. KING OF DE	Join Toda II	addily.		
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, Ma	0 8 8	19a. Informent's Name/R THOMAS H. MO								SBURY, MD 21804						
a ~	of Haa Item 2	20e. Method of Dispositio				Piece of Disp	osition (Ner	me of		own, Stete						
Pages	Department of important: If I any Injury or ance.	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) PARSONS CEMETERY 12/10/99 SALISBURY,										, MD				
m s	hysician /Medical xaminer	23a. Pert1. Enter the disa shock, or heart feilu Immediate Ceuse (Finel disease or condition resulting in deeth)	re. List only o	ne ceuse on	testeti	th. Do not er	nter the mod	de of dyin		s cerdiec o	E, INC. or respiretory erro			MD 21804 Approximete Intervel Between Onset end Deeth		
Box 68760,	nding physician and use es the burlet-transit in/Medical Examine	Ceuse (Disease or injury that initiated events Due to (or es e consequence of):														
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Hec we	has b							,				~		deeth?		
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of Vita	is certification of director	exeminer?	-	Hospital:	Inpatient 2	ER/Outpatie	ent 3 DC	Oth-			me 5 Reside		er (Snec	ifu)		
a Phys	er this	27. Menner of Death	1 Daniel de la	28e. Dete		28b. Time injury		28c. Injun Worl			28d. Describe ho					
Vision	or: Aft he fur	2 Accident	Pending investigation	(1010)	an, Doy roar,	,,	М		Yes 2□							
Division or Attending	rs aftar death. al Director: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homloide	Could not be determined	28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)					28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)							
To the Hospital	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp			ner: On the b	asls of exemine						end due to the cred et the time, d					
o the	outhin comple	29tr. Signature and title of	certifies	- ond mer	nner stated.)	296	c. Licens	e number			9d. Date signe				
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		30. Name end eddress of	person who c	ompleted ceu	se of deeth (Iter	n 23a) (Type	, Print)	-)	,	0 1	1			67		
	5	31. Dete filed (Month, Da	W YOUR WILL	0 /	45E.	Cour	5//	57.	5	1×/×	1	MO 2	-15			
	State Registrar		9 1999		Registrer's Sign	G.	do	rely.	/		01					
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Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended ItemS310a,b,ce,f perFH G779 1/15/2000 EW Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey **Physician** Arthur Donald Miles December 8, 1999 6:45 PM /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Vicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Hours 213-24-0369 69 Director Dec 9, 1929 MD Usuel Residence of Decedent 10b. County Bergen 10a. State 10c City Town or Location 10d. Inside City Limits MD- NJ Wicomico Teaneck 1 X Yes 2 □ No Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1108 Mincola Ave. 1100 Allan Court 21801 07666-5502 234 U.S. Funerai 12. Wes Decedent Ever in U,S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Meritel Stetus 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black Specify: þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 4 Counselor Social Services is 1 and 2 should be filed voil Heelth and Mental Hygie flem 27 is marked other to other traumatic event, to Saltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Grant Miles Bessie Pitts 19a. Informent's Neme/Reletionship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Betsy Miles/daughter 1000 Allan Court, Teaneck, NJ or other 20b. Place of Disposition (Name of cemetery, crematory or other plece) Pages 1 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removel from Stete Department of Important: If any injury or page. Green Acres Mem Park 12/11/99 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Forteral Service Ligensee 22. Neme end Address of Fecility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a Part: Enter the disease, on complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** . En Stoge Blecholie Centrosis Immediate Cause (Finel disease or condition resulting in deeth) yenges /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed the burial-tren Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Due to (or es e consequence of) P.O. ate has been signed by the a page 2 should be detached Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wera eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutoosy certificate 1 Yes 26 No 1 Yes 2 TNo of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation Neturel death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 ☐ HomicIde Mospital 24 hours a Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier (Check only one) within 2 To the \$ 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

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31. Dete filed (Month, Dey, Year)

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DHMH 16 Rev 6/95

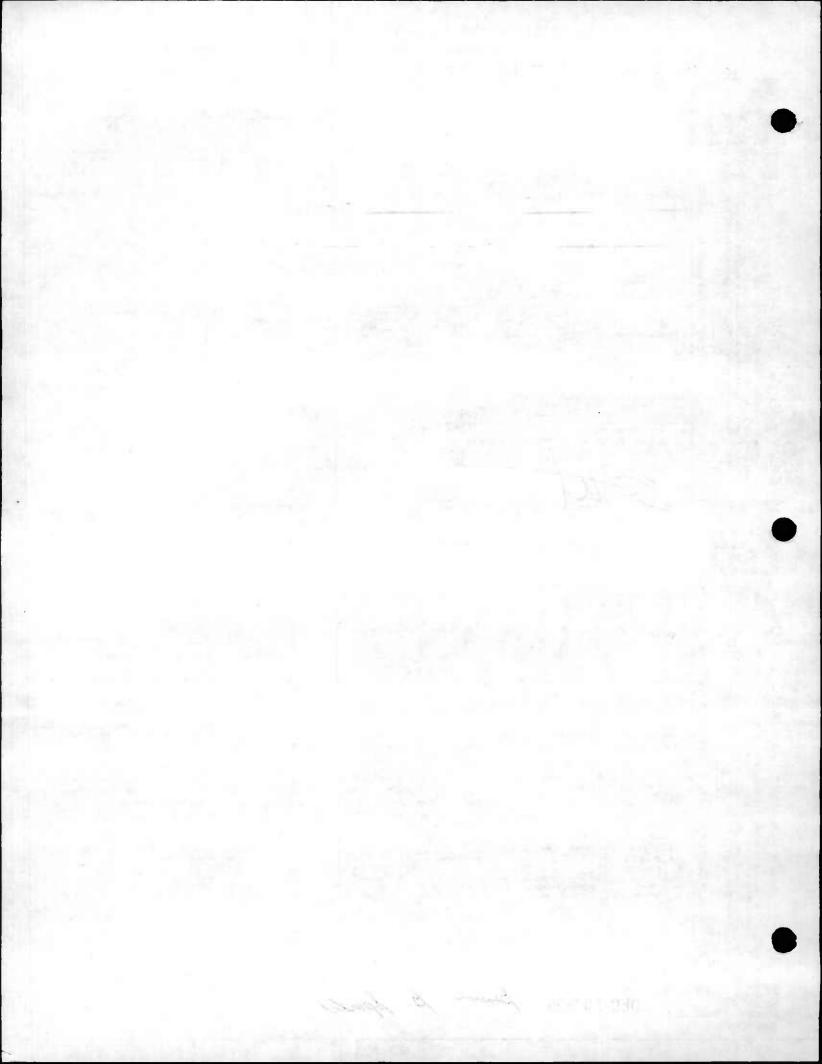
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DOZINE Solisses MO 21804

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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32/Registrer's Signeture



should be det re Hospital or Attendi n 24 hours after deeth. He Funeral Diractor: A pletely filled in by the fi

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Attending Physician:

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Certification:	2
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23b. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCENE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred SUBJECT 27. Manner of Death 28b. Time of 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) Injury 1 Natural 5 Pending BURIED UNDER TRASH 12-22-99 1 Yes 2 No 2 Accident investigation UNKNOWN 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number City or Town, State) 8 U / BROCKBRIDGE 4 Homicide WORK SITE WORK SITE ROAD JESSUP, MD

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Dey, Year) luter

24b. Were eutopsy findings eveilable prior to completion of cause of death?

15 10s 2 No

December 23, 1999

State Registrar

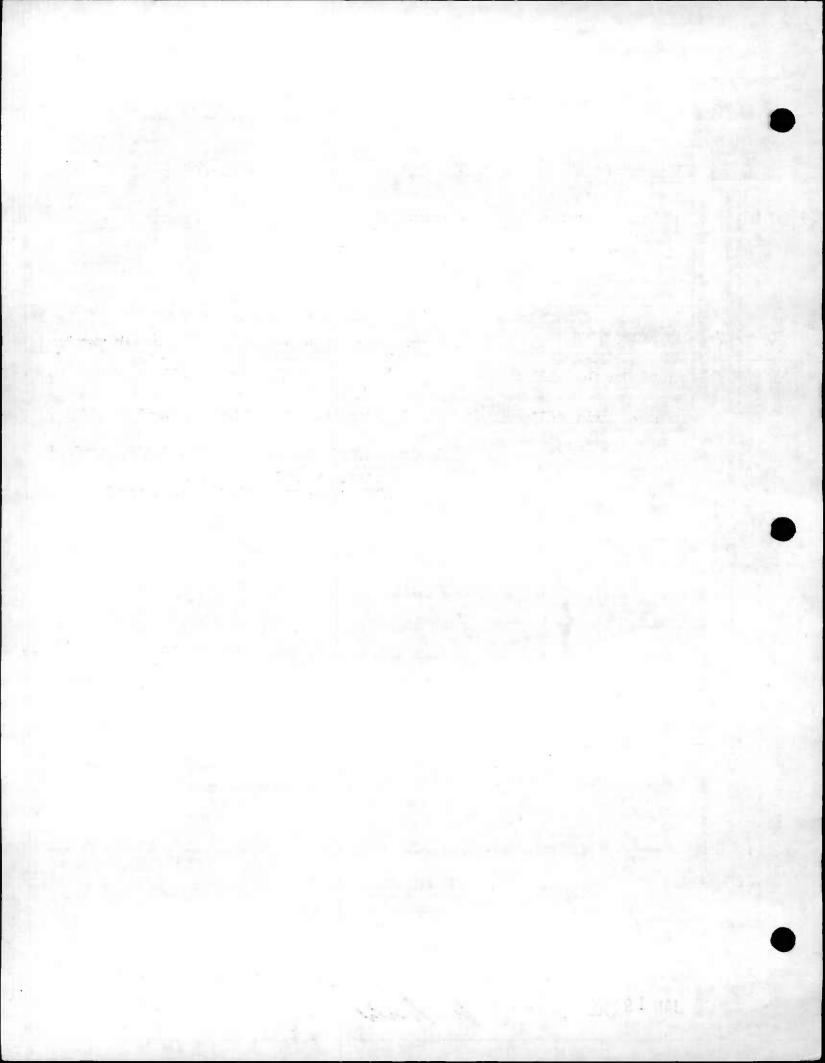
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huteno nni 31. Date filed (Month, Day, Year) 32. Registrer's Signeture JAN 19

Name end address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Sparker

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14्वंव URTIS 1. 155 NUTTER 6-4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death If Under 24 Hrs. 8. Dete of Birth Hours Min. 8. Month, Day, 23546 CAPITOLA RD Icomico If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 100M 2□ F Months Days 220-03-8413 90 Yrs. MD Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 100M100 1 Yes 2 No YASKIN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21865 23546 CAPITOLA RI U.S 12. Wes Decedent Ever in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Yes 2 D No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1□Yes 20 No Specify: Specify: BLACK 3 Dewidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transfer Station Attendant 17. Father's Name (First, Middle, Last) WIC, CO 18. Mother's Neme (First, Middle, Maiden Surname) HENRY NUTTER 19a. Informant's Name/Relationship (Type, Print) Daughter MAGGIE lunknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2354 CAPTIOLA RD NUTTER TYASKIN MD 21865 Date 20c. Location - City or Town, State MANNE 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 1 Deurial 2 □ Cremation 3 □ Removel from State 199 TYASKINIMID 12 4 ☐ Donetion 5 ☐ Other (Specify) WHITE HAVE COMETER 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately and the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately and the disease of the Approximete Intervel Between Onset and Death Immediete Ceuse (Final disease or condition resulting in death) PROSTATE METASTATIC CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco uss contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home S ☐ Residence 8 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hyglene. Important: If itsm 27 is marked other than "natural", or fler any injury or other traumatic event, the Medical Examples

Baltimore, Maryland 21215-0020

death with the Merylend

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Examiner Physician/Medical þ Completed Be 2 Certification:

80 ettending | ate hes been signed by the page 2 should be deteched certificate director, this funeral

physician end s the buriel-transit be executed

P.O. Box 68760, Records, Division of Vital To the Hospital or Attending Pt. within 24 hours efter death.

To the Funeral Director: After the completely filled in by the funeral

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and menner stated. Medical 29b. Signeture and litle of certifier

29e. Certifier

27. Manner of Death

1 Natural

2 Accident

3 Sulcide

4 | Homicide

5 Pending Investigation

6 ☐ Could not be determined

2 STEP 45N 31. Date filed (Month, Day, Year) State DEC 0 9 1999 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H, LAFFEY

MD 32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

PUBER 121 NANTI COLLE MD 21840 oaks

28c. Injury at Work?

29c. License number

D20683

1 ☐ Yes 2 ☐ No

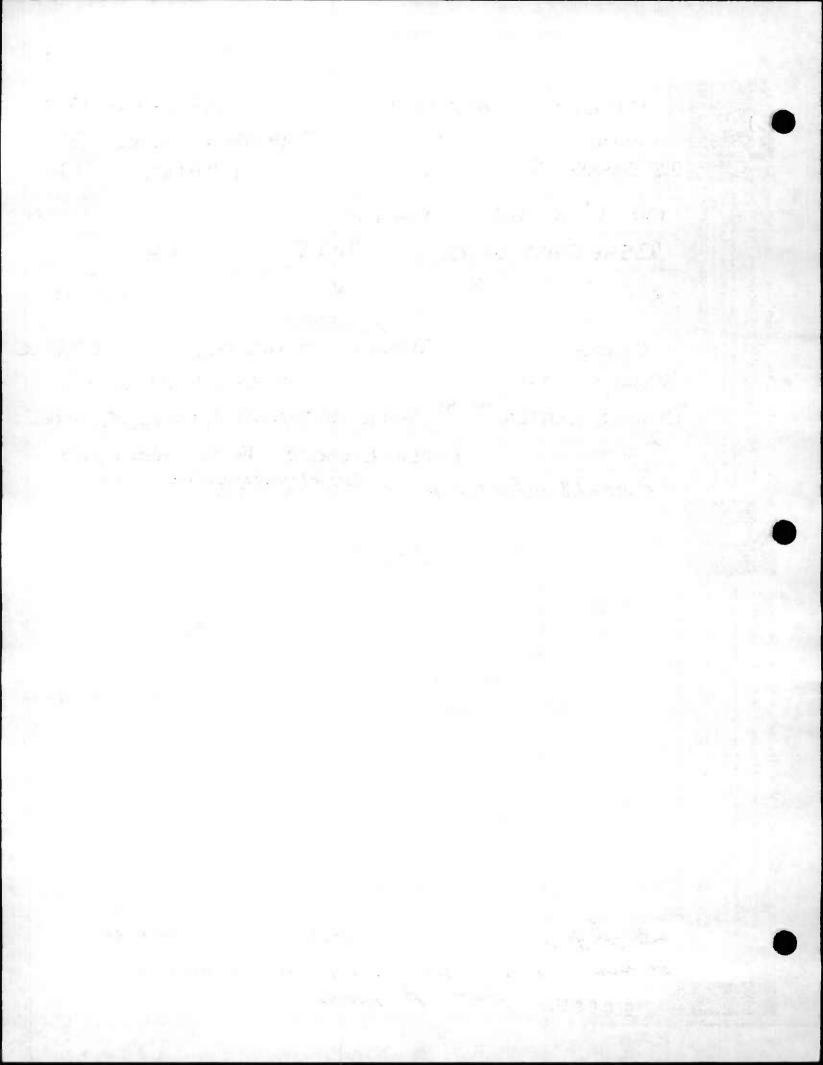
28d. Describe how Injury occurred

Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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DHMH 16 Rev 6/95

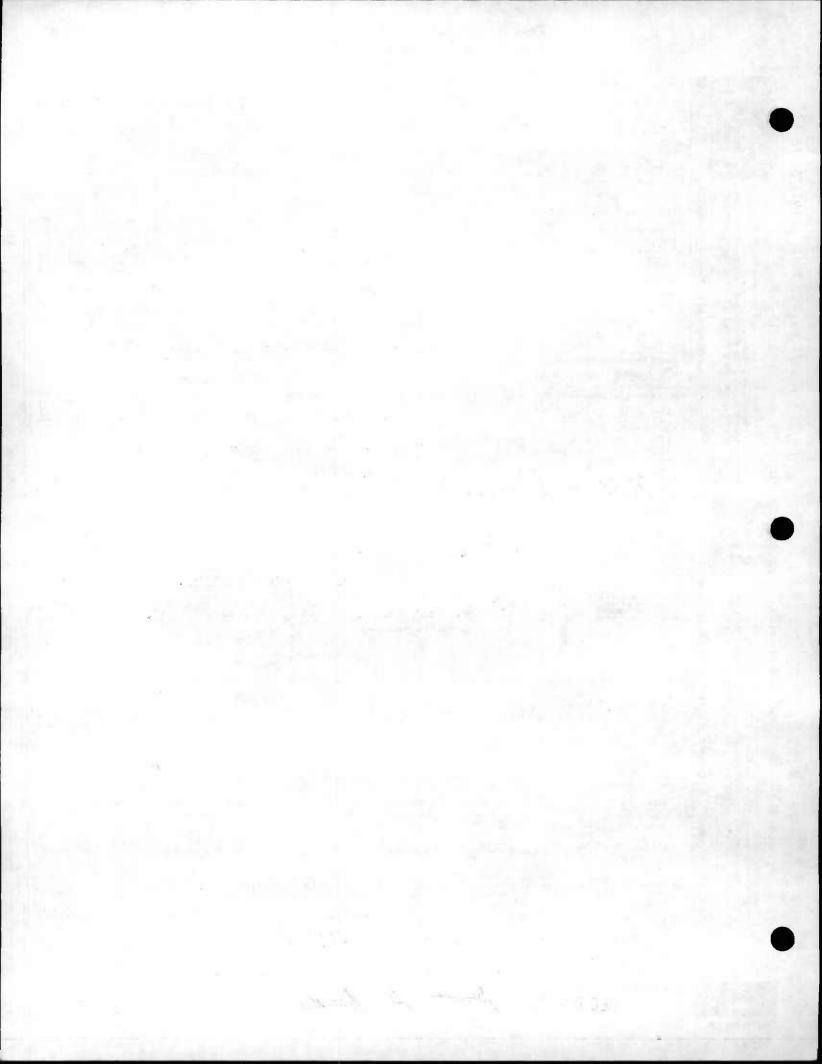


Donald Neal SS# 219-56-7020

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PENINSULA REGIONAL MEDICAL CENTER SALISBURY 5. Social Security Number 219-56-9020 Usuel Residence of Decedent 10a. Stele 10b. County Maryland Wicomico Salisbury 10c. City, Town or Location Salisbury 10d. Zip Code 10d. Zip Code 11d. Meritel Stetus 11d. Meritel Stetus 11d. Never Merried 11d. Stele 11d. Wes Decedent Ever in U.S. Armed Forces? 11d. Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11d. Never Merried 11d. See 2 No. Specify: 11d. Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11d. Yes 2 No. Specify: 11d. Yes 2 No. Spe	County of Deeth WICOMICO 9. Birthplaca (State or Foreign Country)
DONALD G. NEAL	County of Deeth WICOMICO 9 Birthplaca (State or Foreign Country) 2 Maryland 10d. Inside City Limits 1 □ Yes 2 ☑ No zen of What Country? USA 14. Race - American Indian, Black, White, etc.
Funeral Director 4e Facility Neme (If not institution, give street and number) PENINSULA RECIONAL MEDICAL CENTER 5. Social Security Number 219-56-9020 12 M 2 F 47 Yrs. 6. Sex 219-56-9020 13 M 2 F 47 Yrs. 6. Sex 219-56-9020 14 M 2 F 47 Yrs. 6. Sex 3	WICOMICO 9 Birthplaca (State or Foreign Country) 2 Maryland 10d. Inside City Limits 1□ Yes 2√2 No ten of What Country? USA 14. Race - American Indian, Black, White, etc.
Director 219-56-9020 12 M 2 F 47 Yrs. Months Days Hours Min. (Month, Day, Year) June 5, 195 Usual Residence of Decedent 10a. Stete 10b. County Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10f. Zip Code 21804 11. Mental Stetus 1 Newer Merried 2 Married 1 Newer Merried 2 Married 3 Widowed 4 Divorced 1 Newer Merried 2 Married 1 Yes 2 No Specify: 1 Yes 2 No Specify:	2 Maryland 10d. Inside City Limits 1 □ Yes 2 ☑ No zen of What Country? USA 14. Race - American Indian, Black, White, etc.
Usuel Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 21804 11. Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 Yes 2 No Specify: Yes or No-lif Yes, Give 1 Yes or No-lif Yes, Sive 1 Yes or No-lif Yes or No-lif Yes or No-lif Yes, Sive 1 Yes or No-lif Yes, Sive 1 Yes or No-lif Yes, Sive 1 Yes or No-lif Yes or No-lif Yes or No-lif Yes, Sive 1 Yes or No-lif Yes, Sive 1 Yes or No-lif Yes, Sive 1 Yes or No-lif Yes or No-lif Yes or No-lif Yes, Sive 1 Yes or No-lif Yes or No-lif Yes, Sive 1 Yes or No-lif Yes or No-lif Yes, Sive 1 Yes or No-lif Yes or No-lif Yes or No-lif Yes, Sive 1 Yes or No-lif	10d. Inside City Limits 1 □ Yes 2 ☑ No ten of What Country? USA 14. Race - American Indian, Black, White, etc.
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10e. Street and Number 1016 Pierce Ave. 11. Meritel Stetus 11. Meritel Stetus 11. Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Education 16. Zip Code 21804 10f. Zip Code 21804 10g. Citic 11g. Mest Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Ves 2 X No Specify: 11g. Necessity Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian, Black, White, etc.
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(Specify only highest grede completed) (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired)	nd of Business/Industry
College (1-4or 5+) 12 College (1-4or 5+) Assembly Technician Dre	ess Industries
Tr. Father's Neme (First, Middle, Last) Walter Gorman Neal 19a. Informent's Neme/Reletionship (Type, Print) Poborab I Noal (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number, City or Noal Informent's Neme (First, Middle, Maiden Street and Number or Rural Route Number)	dkins
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	lisbury, MD
21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Holloway Funeral Home Profession 501 Snow Hill Rd., Salisbury,	ional Association MD 21804
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line.	Approximete Intervel Between
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Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of):	
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Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco of the page o	INo 3 Probably 4 Unknown
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1 Yes 2 to the control of the cont	
L S @ 5	3 □Other (Specify)
27. Menper of Deeth 28e. Dete of Injury 28b. Time of Work? 28d. Describe how injury 28d. Describ	y occurred
1 Netural 5 Pending (Month, Dey Year) Injury Work? 1 Yes 2 No 2 Accident 3 Suicide 5 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office 28t. Location (Street ann	
28e. Dete of Injury 28c. Injury et Work?	d Number or Rurel Route Number,)
29a. Certifier (Check only (Ch	end menner es stated. plece, end due to the cause(s)
end menner steled. Signeture and title of certifier 29c. License number 29d. Date	e signed (Month, Day, Year)
121 F18 PIG Fin measured	13/89
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) OHNCY (MED DIVE Selectory W.D. 2180 (
State Registrar DEC 0 6 1999 32. Registrer's Signeture G. Apauls	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4b. City, Town, or Location of Death 4c. County of Death James Randolph Powell 6:40 AM /Medical 4a Facility Name (If not institution, give street and number) Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1KIM 2□ F Months Days Hours Yrs. Director 84 NOV. 5,1915 VIRGINIA 217-10-2335 Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at YE Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò "natural", or items 23a 724 JACKSON ST. U.S.A. 21804 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or her eny injury or other traumatic avent, the Medical Landing 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: à 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 TRUCK DRIVER POULTRY INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JESSE** POWELL. WILLIE GODWIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 JACKSON ST. HILDA A. POWELL - WIFE SALISBURY, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State PARSONS CEMETERY 12/9/99 4 □ Donation 5 □ Other (Specify) SALISBURY, MD 21. Signature of Funeral Service Licensee 705 E. MAIN ST. 22. Name end Address of Facility CF SPBOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner sloien and bural-transit requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien for use as the buria Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ NO of Vitai ospital or Attending Physicien: I hours after deeth. unerel Director: After this certifica sky filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitat 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of tnjury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division 5 Pending investigation 1- Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be within 24 hours after de To the Funeral Director completely filled in by the 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated. edical

State Registrar

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(Check only one)

29b. Signature and title of certifier

M ATKINS 31. Date filed (Month, Day, Year)

DEC 0 7 1999

30. Name and address of person who completed cause of death (flera 23a) (Type, Print)

MATKINS ((C)) Residence:

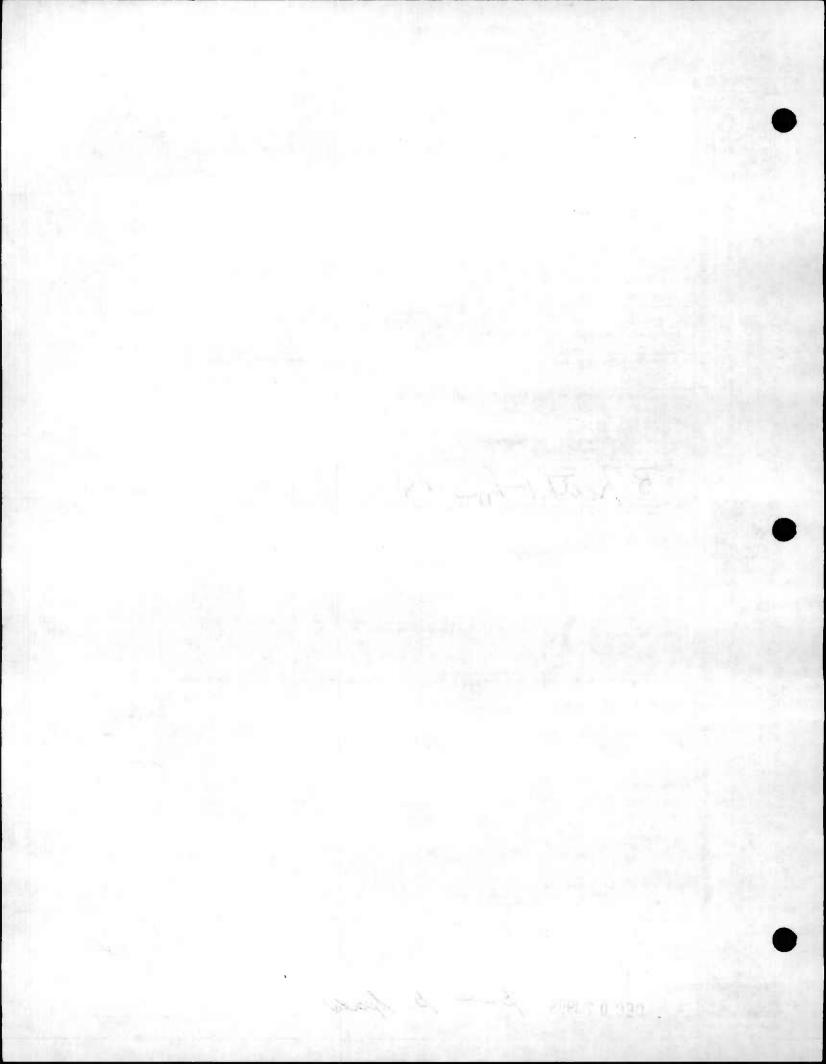
32/Registrar's Signature

ner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

solis up 21804



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

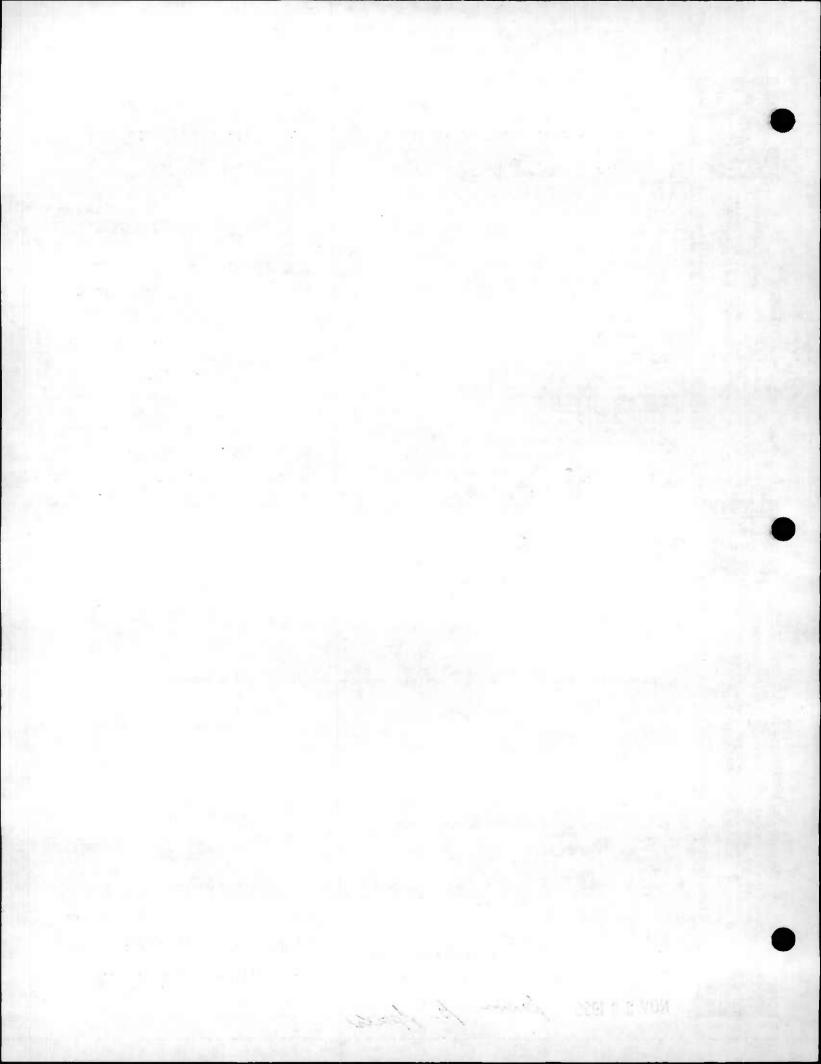
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Month 3 Time of Death Day **Physician ELMA PARSONS** NOJEMBER 29, 1999 0629 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) July 20,1920 6 Sax Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 79 Director 214-10-8839 Maryland Usual Rasidence of Decedant 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits ty⊡ Yes 2 No Director Maryland Wicomico Salisbury 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 230 809 Spring Ave. 21804 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian. Bleck, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Married Maryland 21215-0020 b 1 Yas 2 No Specify: Specify White P. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Dresser Industries 11 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Herman Lee Bailey Beatrice Marie Hastings 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mattie M. Bell/Sister 809 Spring Ave., Salisbury, MD 21804 Important: If Item 27 any injury or other to Saltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata DE Burial 2 ☐ Cremation 3 ☐ Ramoval Irom Stata 4 ☐ Donetion 5 ☐ Othar (Spacify) Wicomico Memorial Park 12/2/99 Salisbury, MD 22. Nama and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licenses MOIDSI NO 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cause or each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finat disaase or condition resulting in deeth) /Medical Prenum.c Examiner Due to (or as a consequence of): Physician/Medical Examiner Aspinations anding physician and use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 10 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician; director, 25. Was case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Impatiant 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yas 2 No this funeral 28c. tnjury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After t Hetural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 24 hours after death. 2 Accidant 6 Could not be datarmined 3 ☐ Sulcida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - Al home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide filled Hospital 29a. Cartifiar 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date end place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 10 Salisbury Obk ocker Dowen 1+1 100 MB 31. Data iiled (Month, Day, Year) 32. Registrer's Signetura State NOV 3 Registrar 0 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended # 23a, Part 1 12/13/99 WCHD HILC Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev **Physician** Month KATHLEEN ELIZABETH **PETERS** 8:00 P.M. 99 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WICOMICO SALISBURY 328 DELAWARE AVE. If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 9. Birthplece (Stete or Foreign **Funeral** 10 M 2 F Months Deys SALTSBURY 79 Yrs. Director 218-20-6839 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show MD. WICOMICO YOYes 2 No Director SALISBURY 10e. Street end Number 10f. Zip Code 10a. Cifizen of What Country? USA 21801 328 DELAWARE AVE. Funeral 12. Was Decedent Ever In U,S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 ò 1 Yes 2 No Specify: by Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ni any injury or other fraumetic event, the Mestal once. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER DOMESTIC 11th Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be MATTIE DANIELS To STANSBURY PARSONS 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) WILLIAM R.S. PETERS/SON ADDRESS SAME AS ABOVE Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GREEN ACRES MEM. PK. 12-13 WEST RD., SALISBURY, MD. 22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 21. Signature of Funeral Service License 1213 JERSEY ROAD, SALISBURY, MD. 21801 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CONGESTIVE HEART FAILURE Examiner Due to (or as e consequence of): Ischemic Examiner TSCHEMIC CARDIOMY OPATHY The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. COPONARY ARTERY DISEME Physician/Medical Due to (or as a consequence of): the P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown SEVERE MITRAL REGULGITATION Records, þ 24b. Were eutopsy findings evaileble prior to Be Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation efter death. Director: Af 2 ☐ Accident 1 Yes 2 No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 Homicide ò _ To the Hospital of within 24 hours e To the Funeral D 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dey, Year) 010 13

muleted cause of death (Item 23a) (Type, Print)

35 Registrer's Signature

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State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40855 Certificate of Death amend item per phy G780 2/24/00 yg 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Middle, Last) Dorthalee Mith Ropp Dorothalee Michael Ropp **Physician** Dec. 11, 1999 ee 12:22 PM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 5 Walnut St. Myersville Frederick if Under 24 Hrs. Hours Min. If Under 1 Year 8. Dete of Birth (Month, Dev. Yeer) Mar. 12, 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months 218-34-3408 1 M 20 F Director 1936 MD. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits Examiner must be notified at Director MD. 1 XYes 2 No Frederick 5 Walnut St. Myersville 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 5 Walnut St. 238 21773 U.S.A. death Funeral Herns 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritei Stetus permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Experimentals. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) communications specialist federal government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be C. Lloyd Michael Josephine Wolfe 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) M. Lee Ropp (Husband) 5 Walnut St., Myersville, MD. 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Lutheran Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 12/15 Middletown, MD. e of Funerel San 22. Name and Address of Fecility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769 23a. Part1. Enter the disease, or cotrus cetions that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only the cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760, physician s the buria thet initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. I Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Dtd tobecco use contribute to the cause of death? 1 Yes 25No 3 ☐ Probably 4 ☐ Unknown signed b Records, þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? pege 2 should Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home State Residence 6 Other (Specify) 70 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA After this illed in by the funeral 27. Manner of Deeth Certification:

28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

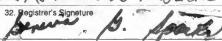
29c. License number 29d. Dete signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

MEDICAL CONFER HAGENSTON M.D. 2/748 ROD INWOOD TNIGEOREE NEWMAN 31. Dete filed (Month, Dey, Yeer)

State Registrar

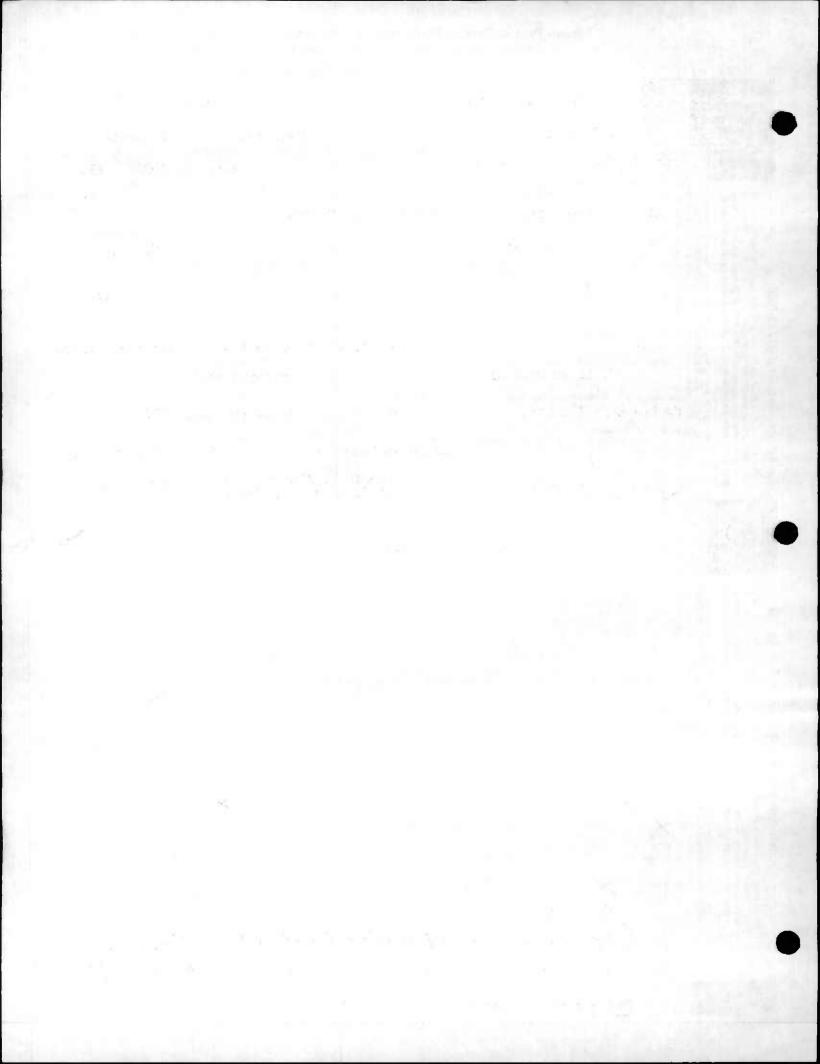
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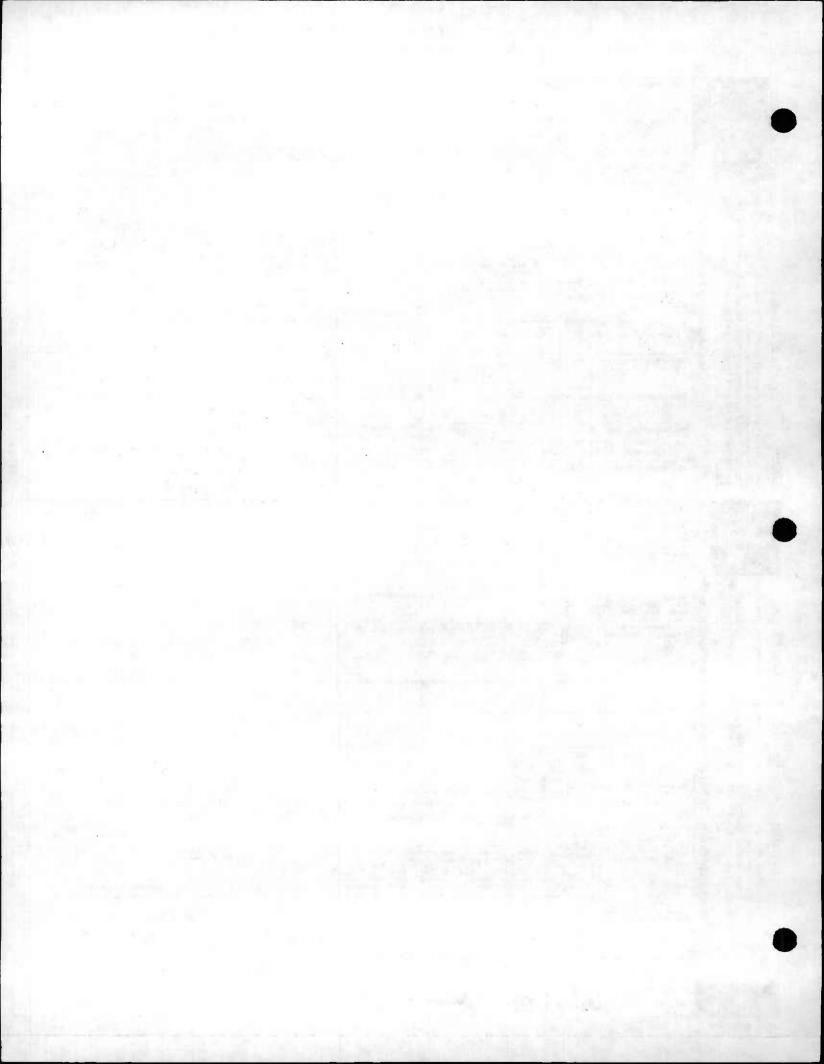
To the Hospital within 24 hours e To the Funeral Completely filled



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey Physician 15, MINERVA CHRISTINE ROPP Dec. 6:50 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 628 Trail Avenue Frederick Frederick H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
May 9, 1927 If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Yes Director 215-20-8465 72 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1) Yes 2□No Maryland Frederick Frederick Director "natural", or Nama 23a or 28a-f 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 628 Trail Ave. 21701 United States death y Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 11. Merital Status permit. Peges 1 and 2 should be filled within 72 hours after a Department of Heelth end Mental Hygiene. Important: if item 27 is marked other then "natural", or han place. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Technician 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Gordon SMITH Jemima RIPPEON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Ropp / son 628 Trail Ave. / Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removet from State 4 □ Donation 5 □ Other (Specify) Mount Olivet Cemetery 112-18-99 Frederick, Maryland 22. Name end Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** MANY YEARS Immediate Cause (Finat disease or condition resulting in death) /Medical ARTERIO SCLEROTIC CARRIOVASCULAR DISERE Examiner Due to (or es a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): P.O. Box 68760, anding physician use as the burla cause (Disease or inju that initieted events resulting in death) Last Due to (or es a consequence of) signed by the atte Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of VItal Records. à Completed 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificata funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No B 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28d. Describe how injury occurred 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1-ENatural in 24 hours after death.
The Funerel Director: After the funerel Director: After the funerel by the fur-5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide McCertifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as steted.

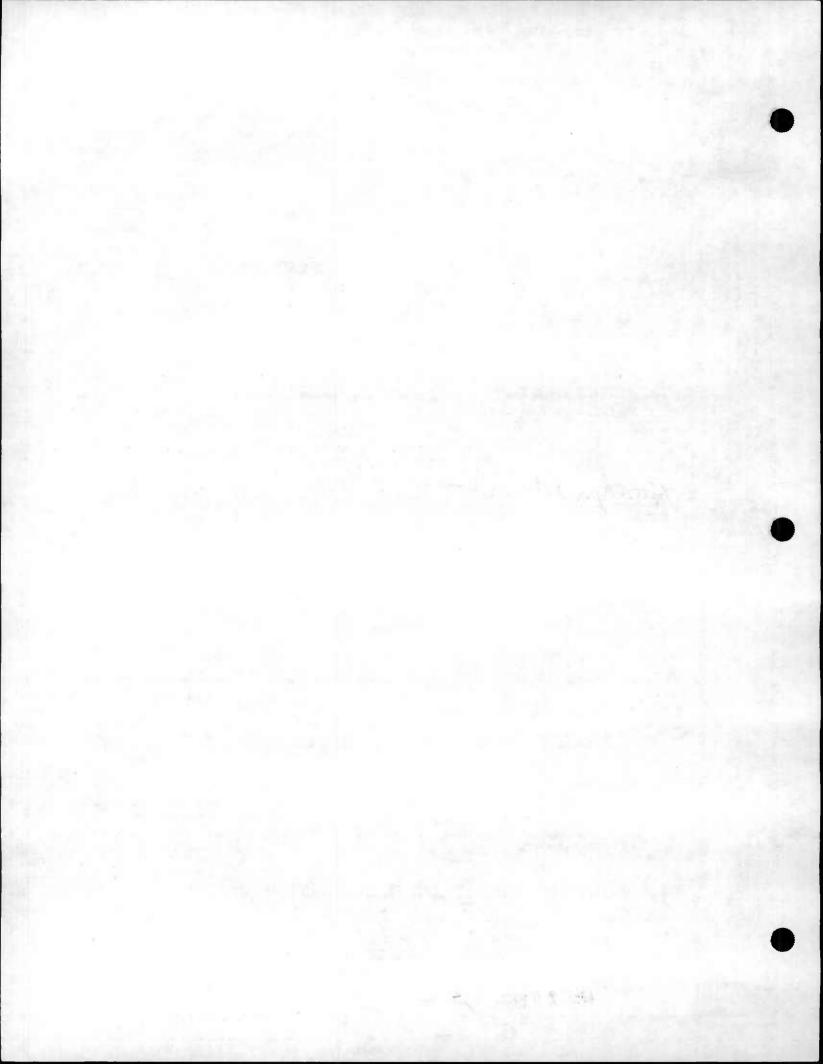
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor. To the Funel completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of continu 016675 MD 2/15/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hugher MD. WHINE 31. Date filed (Month, Day, Year) 32. Registrar Signature State 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death **Physician** Robert Charles Reidt December 18, 1999 9:40 am /Medical 4a Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. Hours | Min. 5. Social Security Number If Under 1 Year 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2□ F 214-16-1635 Yrs. 78 Director Aug 31,1921 Maryland Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Maryland Frederick Frederick 1 X Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 418 Taney Avenue 21702 234 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ⊠Yas 2 □ No If Yes, Giva WW II Yaar or Datas: 'natural', or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc. permit. Peges 1 end 2 should be filed within 72 hours effer. Department of Health end Mentel Hygiene. Important: if item 27 ie marked other than "naturel", or itel mortant: if item 27 ie marked other than "naturel", or itel and jujury or other treumatic event, the Medical Examine and 1 ☐ Never Married 2 N Married Saltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify: WW TT à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Dealership Car Salesman 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Charles NMT Reidt Mildred Laura 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Titus Reidt/Wife 418 Taney Avenue, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 IX Burlal 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Dec 21, 1999 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signatural of Funaral Service Licens Sperson M00706 106 E Church Street, Frederick, Maryland 21701 23. Part 1. Enter the chasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart theure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediata Ceusa (Final disease or condition rasulting in death) /Medical days Gastritis Examiner Dua to (or as a consequence of): Physician/Medical Examiner Fractured Right Hip 7 days slcian end burial-transit The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury Dua to (or as a consequence of): physician s the burial Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of) use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atrial-septal Defect signed l þ Records. 24b. Ware autopsy findings available prior to completion of causa of death? Completed 24a. Was an eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata of Vital Attending Physicien: funeral director, 25. Was casa rafarred to medical axaminar?
1 ∰ Yas 2 □ No Be 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Division 5 Pending 1 Netural after death. Dec 11,1999 1 Yas 2 No investigation 03:00arM Fell while walking 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 418 Taney Avenue Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) 4 Homicide ŏ filled in At home Hospital 24 hours a Funeral Frederick, Maryland 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) end mennar as stated. Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier D35164 December 18, 1999 30. Nama and address of person who completed cause of death (h vn 23a) (Type, Print) Andrew Zarick, Jr, 1080 West Patrick Street, Frederick, Maryland 21703 M.D. State Registrar

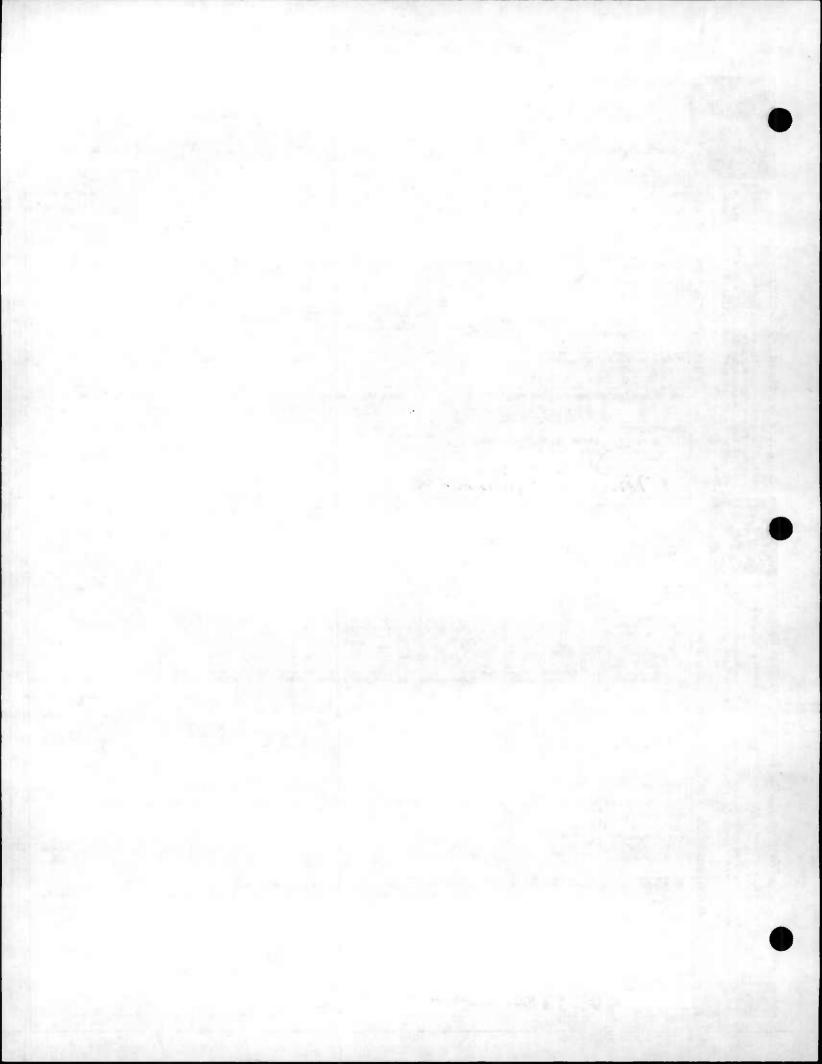
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State of Maryland / Department of Health and Mental Hygiene 0 0 1.00 0

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Physicia /Medica	M = 201	y Fran	ces Ric	cketts				200		cember			5:00	AM
Examine	4a Facility Name (If not						4	lb. City, Town,			4c. County			
	SHADY G						or 1 Year	ROCK\				rgom		
Funeral Director	5. Social Security Number 216–36–216. Usual Residence of Decr	2 11	9X 7. □ M 23② F	Age (In yrs.	last birthday) Yrs.	Months			Vin. (M	ate of Birth fonth, Day, 7. 20	Year) , 1940	9. Birthp Coun Mary	lace (State of try) 1and	r Foreign
Pand Pand		. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inside Ci	ity Limits
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ath with the 23a or 2		view Ro	ad				2175				g. Citizen of V	U.S	.A.	
020 urs	3668 Ridge 11. Marital Stetus 1 Never Married 3 Widowed 4 1		12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	ss? No No		Was Dece If Yes, sp 1 Yes		lispanic Origin? an, Mexican, Pi Specify:	? (Specify Y uerto Rican,	es or No- , etc.)		k, White,	- American Indian, , White, etc. White	
72 hours	15. I	Decedent's Ed	ucation de completed)		16a. Deced	dent's Us	al Occup	ation during most of	working	1	6b. Kind of Bu			
21215-0020 d within 72 hours at giene. or then "netural", or in Medical Even	15. (Specify on Elementary/Secondary 12	, , ,	College (1-4	or 5+)		(Give kind of work done during most of work life. DO NOT use retired) Food Clerk				Safeway Market			Food	
	17. Father's Nama (First,	Middle, Last)							Name (First	t, Middle, M	laiden Sumem	e)		- 1111
ylan ould be Mentel arked o		Edward Moran						Et	hel l	May				
Mar nd 2 sh lith and 27 is m	19a. Informant's Name/F									Rural Route Number, City or Town, State, Zip Code) Ijamsville, Maryland 217				54
Baitimore, N permit. Pages 1 and; Department of Heelth Important: if Item 27 i any Injury or other tr once.	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cre 4 🗆 Donetion	mation 3 🗆		ate C	Place of Dispo cemetery, crer rklawn	matory or	other plac		Dat 12/1		Rockvi			and
Physician /Medical Examiner	23a. Pert1. Entekthe dis shock, or heart failt Immediata Cause (Final disease or condition resulting in death)	saasa, or compute. List only co	Millushications that cause on each	TATIC	th. Do not ent	26401 ter the mo	Rid de of dyin	oleswor ge Road ig, such as can	rth P. 1, Dam diac or resp	A., F	uneral , Mary si,	land		ween Death
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death ce attendi	Part II Other significant	conditions co	ntributing to deat	h hut not ree	ulting in the u	nderlying	causa div	en in Part I	1 :	23h Did to	hacco use co	atribute to	the cause i	of death?
	É	onditions to	ontributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of de				
Of Vital Records, P.O. BO: Physician: The law requires that the death or this certificate has been signed by the attend rel director, page 2 should be detached for us	Ag panel								2	4a. Was ar perlom				
The lay	Ę									1 ☐ Ye	s 2 No	10	Yes 2	No
Vital I	25. Was case referred to examiner?	medical						26. Place of	Deeth (Che	ck only one	9)			
of Vita Physician: this certific rel director.	1 Yes 20 No		Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho							5 🗆 Reside	nce 6 Oth	er (Specif	y)	
VISION O Attending Ph ir death. ector: After th by the funerel		Pending investigation	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	М	28c. Injur Wor 1 🗆	yat k? Yes 2 □ No	28d. C	28d. Describe how injury occurred				
Division To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After completely filled in by the fune		Could not be determined							28f. Location (Street and Number or Rural Route Number, City or Town, State)				iber,	
Ne Hospital Ne Funeral Pletely filled			sician: To the be iner: On the basi and manner	s of examina										s)
To the within 2 To the comple	29b. Signature and title of the second of th	of certifier	mul	Mil)	25	AR YO	e number	424	52 D	d. Date signed	d (Month,	Day, Year)	799
	30. Nama and addrass of 9715, ME.	person who c	centre	of death (Item	1 23a) (Type,	Print)	De. 221	CH MRA ROCK	VILLE	JAGO TAGO	D 208	250		
State	31. Data filed (Month, Da	y, Year)	32. Reg	istray's Signe	eture	4	-	San W.			-		-	

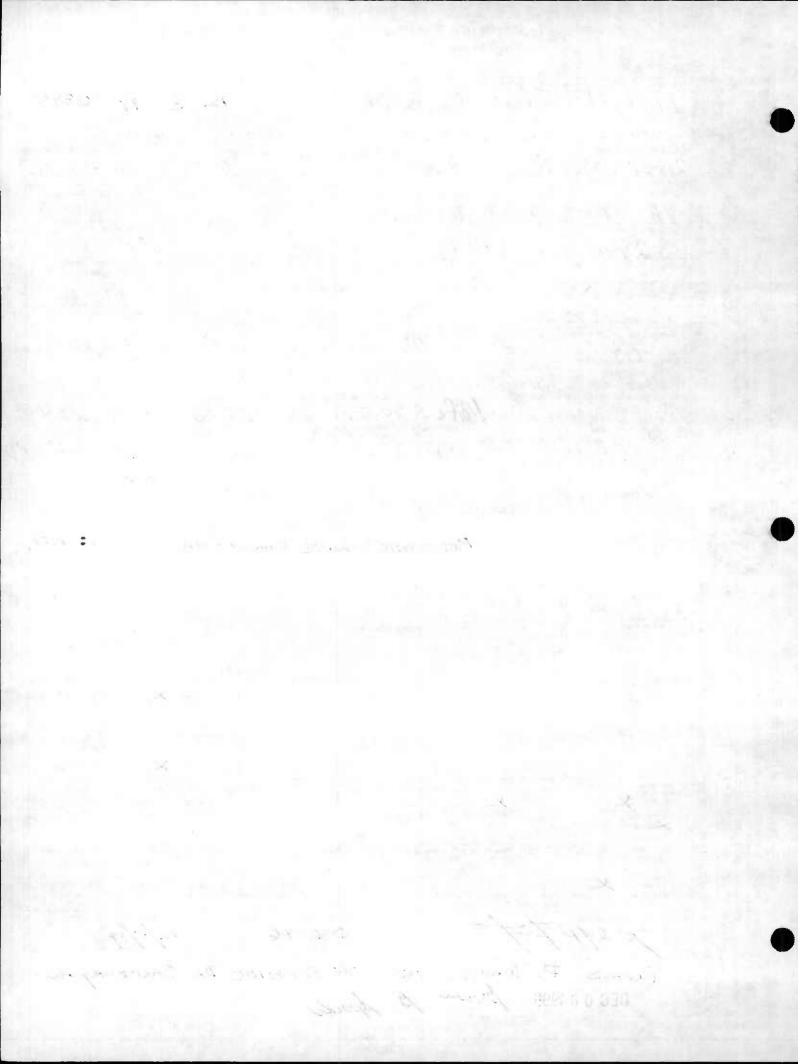


MICHAEL E Roberts

		State of Maryland	_	te of Death		Reg. No.	9 4	0859		
Physicia	1. Decedant's Nama (First, Middla, Lasi	La Rib	1 50		2. Date of De Month	Day	Year	3. Time of Death		
/Medic	An Provide Branch Million Albanda Albanda San	stree and number)	rrs or.	4b. City, Town, or	Location of Deat	4c. County	of Death	0845		
Examin	PENINSULA REGIO	•	NTER	SALIS			OMICO			
Funeral Director	5. Social Sacurity Number 6. Sa			er 1 Year If Under 24 Hrs	8. Data of Bir			aca (Stata or Foreign		
how	10a. Stete 10b. County	10c. City	, Town or Location				10	Od. Inside City Limits		
Trail yidilid within 72 hours after deeth with the Maryland and Maniful Hygene. and Maniful Hygene. are mixed other than "natural", or items 23s or 28s-f show as marked other than "natural", or items 23s or 28s-f show as marked other than "natural". To Be Completed by Funeral Director	& VH Accomac	K Wa	Hsville	ip Code				1 Yas 2 No		
	10e. Street and Number	Jackill Pa		10g. Citizen of What Country?						
ome 2	11. Marital Status	12/Wes Dacedant Evar in U,S Armed Forcas?	S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puar	Specify Yas or No to Rican, atc.)	- 14. Rac	e - Amarica k, Whita, a			
D20 irs afte	1 Never Married 3 Married 3 Widowed 4 Divorced	1 ☐ Yas No If Yas, Give Yaar or Datas:	1□ Yes	1		Specify	0.1	a. W		
Maryland 21215-0020 d 2 should be filed within 72 hours at h and Mentel Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Essen	15. Decedant's Edu (Specify only highast grad	ucation	16a. Decedent's Us	ual Occupation ork dona during most of wo	rkina	16b. Kind of Bu	usiness/Indi	ustry		
vitin in 121	15. Decedant's Edu (Specify only highast grad Elamantary/Secondary (0-12)	Collega (1-4or 5+)	lifa. DO NOT	use retired)	11. 1	1.11	D	10.		
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ylan Suid be Mentel mrked o	e Willie Bi	'show		Sar	ah Ro	berts				
Aarylan 2 should be and Mentel is marked of sumatic ev	19a. Informant's Name/Relationship (T)	(pe, Popt)	19b. Mailing Addres	s (Street and Number or R	ural Routa Numb	er, City or Town,	Stata, Zip	Code)		
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0 5 2 7	1 Burial 2 □ Cramation 3 □ F 4 □ Donation 5 □ Other (Specify)	Ramoval from Stata	matary, crematory or	other place)	10 11 90	Pro	V	1.1.16 M		
Baltim permit. Pag Department important: i any injury o	21. Signature of Funaral Sarvice Licens		22. Nama a	nd Addrass of Facility	12-11-17	1-00011	oke-	Wasataen III		
Dem Depa	Dannie Mouri		Doll	wah Harris-	Nock fu	reval sen	rices			
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thet the	44			10	1 Yes 28 No 3 Probably 4 Unknown					
VITAL RECORDS, P.O. BOX Iclan: The lew requires thet the deeth cert certificate has been signed by the ettending rector, page 2 should be deteched for use a	Completed b				24a. Was an autopsy performed? 24b. Ware autopsy fin available prior to completion of ca of death?					
The lew rate has	Eo						1 Yas 2 No 1 Yas 2 No			
	25. Was casa raferred to medical				ath (Check only o	ona)				
hys his	O 1 Yas 2 No		R/Outpatient 3 C		Homa 5□ Resi)		
ding in.	1/Enatural 5 Pending 2 Accidant invastigation	28a. Data ol Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yas 2 ☐ No	28d. Describe	how injury occur	rea			
dea dea	27. Mannar of Death Description State State State State	28a. Placa of Injury - At hon		ry, office	28f. Location (28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)				
led Dist. C	5	building, atc. (Specify)								
To the Hospital or A within 24 hours star To the Funeral Dire completely filled in b	29a. Certifiar Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of axamination	ledge, death occurred on and/or invastigatio	f at the time, data and place n, in my opinion, death occ	e, and dua to tha urred at tha tima,	causa(s) and ma data and place,	annar as sta and dua to	ited. tha cause(s)		
of the	29b. Signatura and titla of certifier	and manner stated.	25	C. License number		29d. Data signe	d (Month, E	Day, Year)		
- > - 0	> Kuly P.	4		D36576		12/5	189			
15	30. Nama and addrass of person who co	- Contraction of the Contraction	23a) (Type, Print)		116.19					
	RONALD P	- TRAVITZ	NO	560 RIVERSI	DE DR	L SAKI	SBUR	Y MD		
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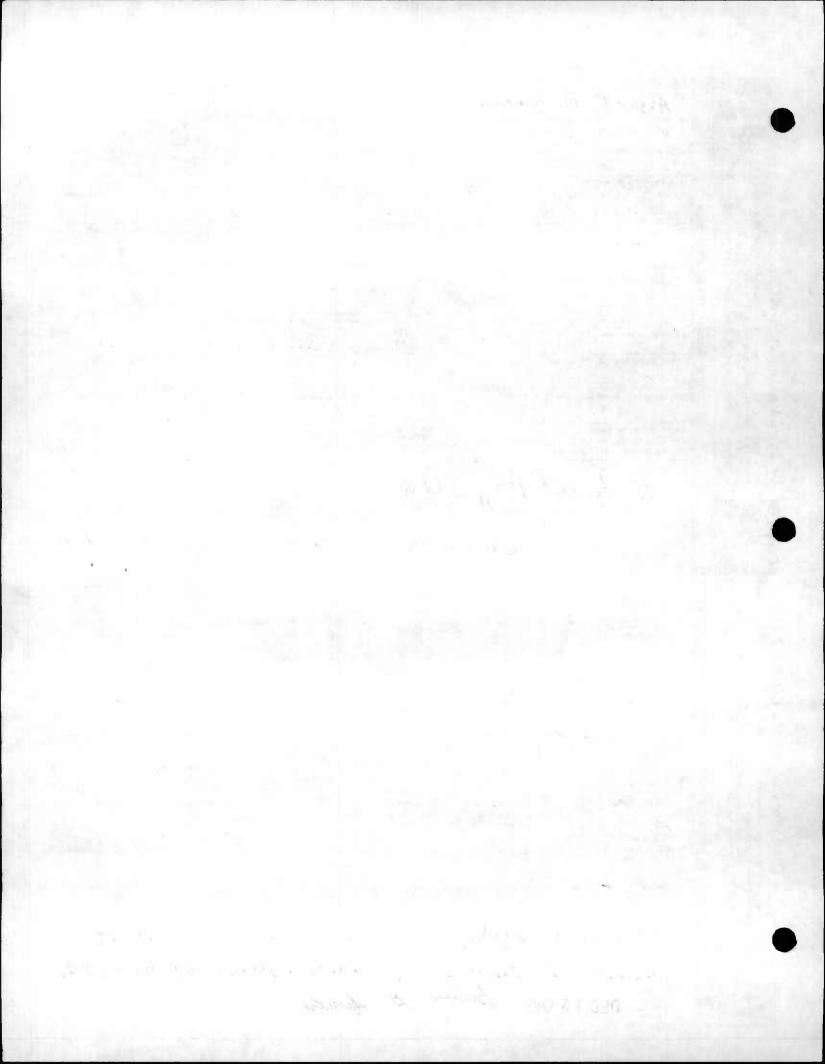
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Albert Month Day Year **Physician** R. RUARK 0540 DECEMBER 16, 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 7,1917 If Under 1 Year 5. Social Security Number 6. Sex 1₽M 2□F 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Deys MARYLAND Yrs 219-05-0248 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryler Department of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified. 14 Yes 2 No Directo MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 TRUITT ST. 21804 U.S.A. Funeral 12. Wes Decedent Ever in U.S.
Agned Forces?
1€ Yes ≥ □ No ARMY
If Yes, Give
Year or Detes: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 ☐ Merried Baitlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 2 3∆ Widowed 4 Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 MAINTENANCE FOREMAN WICOMICO COUNTY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 CYRUS RUARK **BERTHA** RUARK 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA A. TWILLEY - DAUGHTER SALISBURY, MD 21804 31873 YORK DR. 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 Buriat 2 □ Cremation 3 □ Removel from Stete PARSONS CEMETERY 12/13/99 SALISBURY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. SALISBURY, MD 21804 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical yea. Examiner sicien end buriei-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) physicien s the burie Records, P.O. Box 68760. Physician/Medical Due to (or es a consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Probably 4 Unknown s been signed to should be detail þ try dream 24b. Were autopsy tindings aveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 TNo investigation 2 Accident 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 4 Homicide edical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-10-99 122160 30. Name end address of parson wgo completed cause of death (Item 23a) (Type, Print) NAGEL RMC SALISBURY MO 21801 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State DEC 13 1999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40861 Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Joseph 1999 DARNIAK 950 /Medical 4a Facility Nama (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner HUNAROLLS

If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Cove 201 Ca Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 110 M 2□ F Yrs Sept. Michigan Director 372-66-0156 Usuet Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Modical Examinet must be notified at 1 ☑ Yes 2 ☐ No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. # 201 1130 Cove Rd. 21403 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours effar on Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frem any injury or other traumetic event, the Medical Federal 2008. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: g 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Water Treatment Technician 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Joseph Timinskis Ruth E. Fisk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Ruth E. Sarniak / mother 1417 Lincoln Lake Ave. N. Lowell, Mich. 49331-9711 Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 12-16-99 Brentwood, MD Lincoln Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St. Annapolis, MD 21401 Jowe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician ⊮**Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): certificate be axed Division of Vital Records, P.O. Box 68760, physician Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) use as ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No bengis be det g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy been page 2 certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner/ 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 3□ DOA this funarel 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation Natural Hospital or Attending 24 hours eftar death.
 Funeral Director: After 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide 24 hours 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the To the Comple Deputy 29c. Licanse number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) 04 25, MO

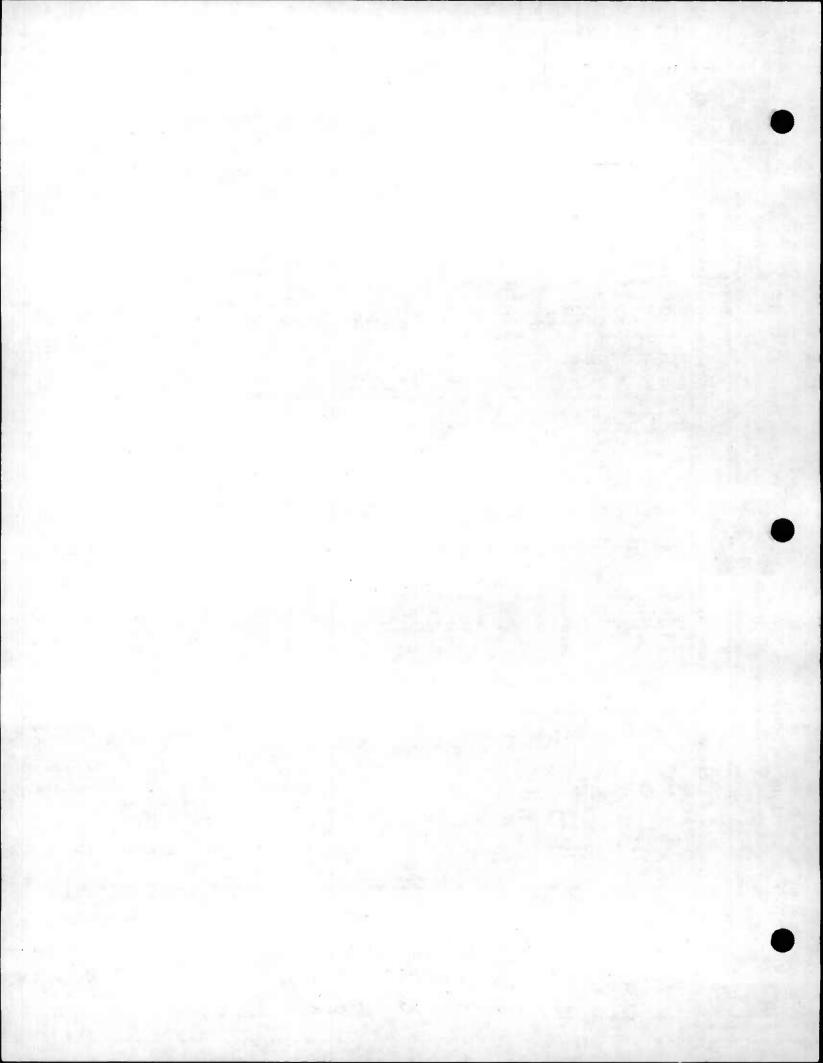
32. Registrar's Signature

State Registrar THE PERSON NAMED IN COLUMN TO SECOND
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Amende	State of Maryland / Department of Health ed Item#5 perFH G780 2/8/2000 EW Certificate of Death	
	Decedent's Name (First, Middle, Last)	2. Dete of Death 3. Time of Death
Physician /Medical	Harold Eugene Shafer 4a Facility Name (If not institution, give street and number) 4b. City, To	December 8 1999 11:55 PM own, or Location of Death 4c. County of Death
Examiner		derick Frederick
Funeral Director	5. Social Security Number 0692 6. Sex 10XM 2 F 7. Age (In yrs. last birthdey) Months Days Hours	r24 Hrs. 8. Dete of Birth (Month, Dey Year) 9. Birthplace (State or Foreign Country) Sept. 17, 1926 MD.
D Bu	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
5-0020 72 hours after death with the Marylan witural, or liters 23e or 28e f show steal Examinar must be notified at ored by Funeral Director	MD. Frederick Myersville	1 ☐ Yes 2 🙀 No
	10e. Street and Number 9098 Dawn Ct. 10f. Zip Code 21773	10g. Citizen of What Country? U.S.A.
	11. Maritaf Status 1 □ Never Married 2 ☒ Merried 1 □ Never Married 2 ☒ Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes ② ☒ No If Yes, specify Cuban, Mexica 1 □ Yes ② ☒ No Specify 1 □ Yes ② ☒ No Specify	T The date of
Maryland 21215-0020 d 2 should be filed within 72 hours at mand Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 15. Decedent's Usual Occupetion (Give kind of work done during modifie. DO NOT use retired) ifie. DO NOT use retired) mechanic	st of working 16b. Kind of Business/Industry automotive
Ind 2		er's Neme (First, Middle, Maiden Sumeme)
ylar ylar Menta Menta ette ev	Osacr L. Shafer Sr.	Maetta R. Engle
Mar 12 sho 15 sho		per or Rural Route Number, City or Town, Stete, Zip Code)
E - 12 64 64	Mildred K. Shafer (Wife) 9098 Dawn Ct., Mye 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	ersville, Md. 21/69 Date 20c. Location - City or Town, State
Baltimore, omit. Papes 1 a beparment of Hea moorant; if Nem ny injury or other nos.	4 Donation 5 Other (Specify) Lutheran Cemetery	12/11 Middletown, MD.
B d d d d d d d d d d d d d d d d d d d		mpson Funeral Home •, Middletown, MD. 21769
Physician /Medical Examiner was transit Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart feilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions,	Onset and Death
ds, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit d by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or es e consequence of):	V
P.O. I at the dead the setsched for Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert	
S, P. es that t igned by be deta by Ph	Chronic destructur lene cleriary	1 Yes 2 No 3 Probably 4 Unknown
requirements	sleep appea	24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death?
= = = = 0		1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
/ita	examiner? Hospital: A Other	e of Deeth (Check only one)
0 5 5 5	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
Division o To the Heapital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide	No 281. Location (Street end Number or Rurel Route Number, City or Town, State)
To the Hospital within 24 hours of To the Funeral I completely filled Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, decard and manner steted.	nd place, end due to the cause(s) end menner es stated. eth occurred at the time, dete end place, and due to the ceuse(s)
To the common	29b. Signeture and title of certifler 29c. License number 29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUI A HA VAY M 14 7 5 tang 31. Date filed (Nonth, Day, Year) 32. Registrar's Signature	ave frederick al 2,702
State Registrar	DEC 1 6 1999 Denve G.	

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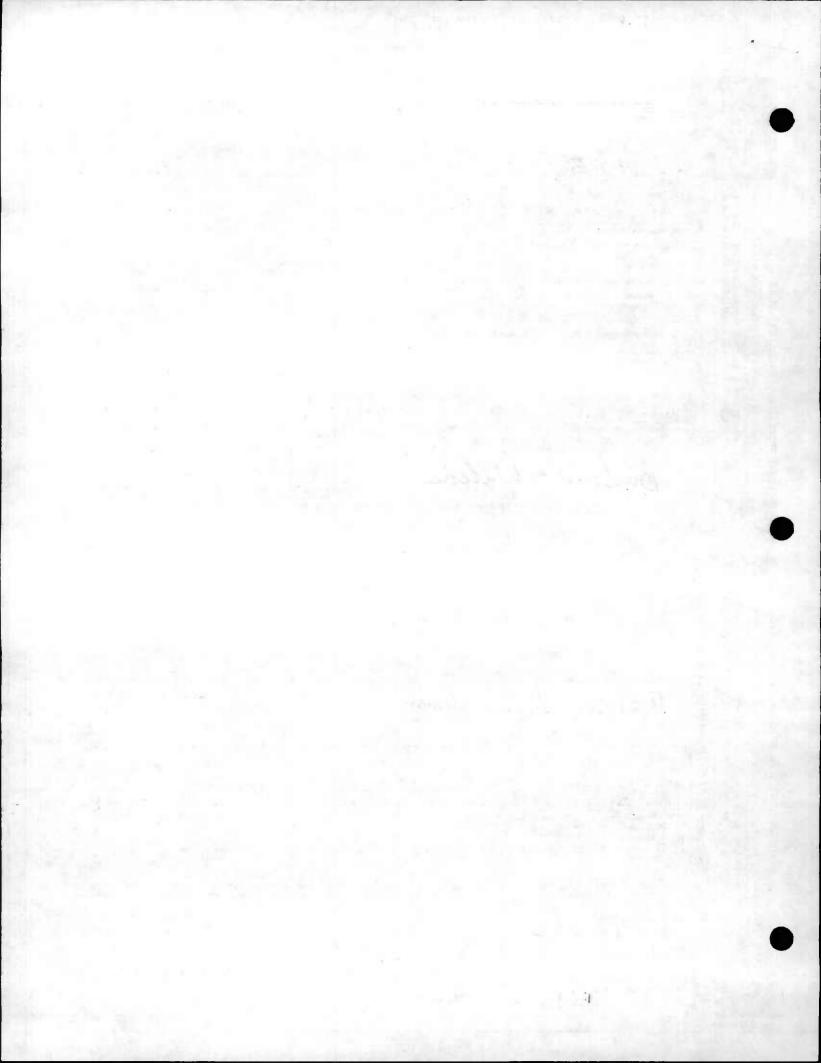
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death FCHD, KS Amended item#lper doctor, 12/15/99 dent's Name (First, Middle, Last) Reg. No. 2. Dete of Death Month Selby **Physician** Hnna Anna Belle Selby 1999 Dec 1:00 a.m /Medical 4b. City, Town, or Location of Death 4e Facility Name (If no institution, give street end number) 4c. County of Deeth Examiner " B " East Street Brunswick Frederick 8. Dete of Birth (Month, Day, Year) 30 1930 Brunswick, MD If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Min 213-24-1 M 20 F 69 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at MD 1 X Yes 2 No Director Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 East "B" Street 21716 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/C/No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health end Mental Hygiane. International 1 ☐ Never Merried 2 ☒ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) N.Y. Hill Grocery Clerk 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Glennie Viola Tederick John Dayton Hite 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 715 East "B" Street, Brunswick, MD 21716 Homer E. Selby, Husband 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 1 ⊠ Buriel 2 □ Cremetion 3 □ Removel from State Park Heights Cemetery 12/11/99 Brunswick, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetule of Fune al Sarvica Licansea Williams, Owner 22. Name end Address of Fecility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrasf, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset end Deeth **Physician** /Medical Immedieta Cause (Finei Minenn diseese or condition resulting in death) Charmetic Examiner Due to (or es a consequence of) Smo 1/1/24 CHONTHE burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting In death) Last Due to (or es a consequence of) and Box 68760. Philmonale Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. á 3 Probably 4 Unknown Yee 2 No bengis d be det Records, þ 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? Completed 24a. Wes an autopsy has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Affer 1 Netural 5 Pending Invastigation a Funeral Director: Atherete Silvers and Property of Fulled in by the fur 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Phyeicfan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. edicai 29e. Certifier (Check only one) To the P within 2 29d. Data signed (Month, Dey, Year) 29b. Signature end title of could be 29c. Licensa number -- 10-99 30. Name end edd ss of person who completed gause of deeth (Item 23a) (Type, Print) Marky //W 32. Registrer's Signeture 610 Ninth Avenue, Brunswick, MD 21716 1 hostople

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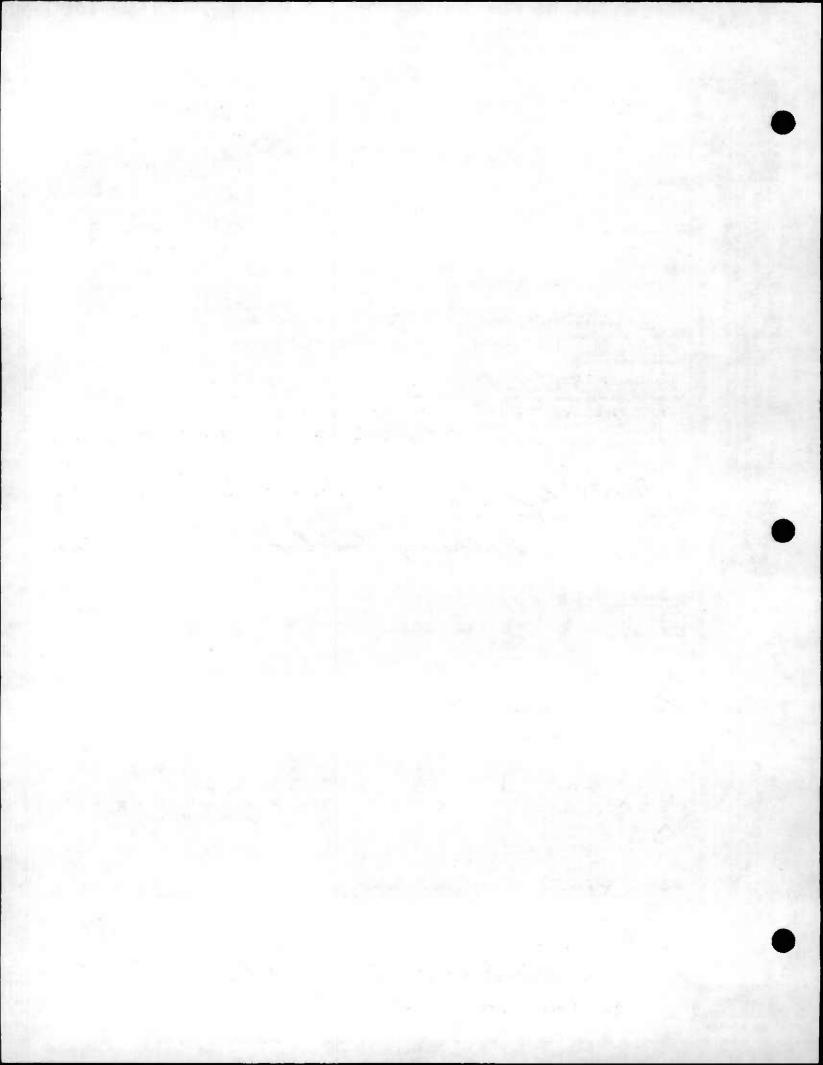
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Physician FRANCIS WITTEN SEXTON Dec. 13, 1999 1600 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 26,1929 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1₽M 2□F Yrs. 70 406-34-0416 Director Usual Residence of Decedent 10e. Stete MD permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or itama 23s or 28s-f show any figury or other traumatic evant, the Medical Examples must be northed at 1908s. 10b. County FREDERICK 10c. City, Town or Location FREDERICK 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 Lee Place 21702 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Rece - American Indian, 11. Maritel Stetus Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: 4 Specify: WHITE 3 Widowed 4 Divorced Yaar or Datas: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) LAB TECH/ADMINISTRATION HOSPITAL Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be GEORGE N. SEXTON MILDRED WHITE 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) NANCY S. SEXTON (WIFE) 506 Lee Place Frederick, Md. 21702 20b Place of Disposition (Name of Residence months beamer plear dens 20e. Method ol Disposition 12/16/99 Frederick, Md. 1 ♥ Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Dother (Specify) 22. Name and Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Fyryeral Se 1201 N. Market Street Frederick, Md. 21701 eath. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Interval Between Onset end Death 232. Pert 1. Enter the disease, or co shock, or heart failure. List or **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence ol) Physician/Medical Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ate has been signe pege 2 should be 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 20€No 1 Tyes 2 No Division of Vital funeral director. Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After Netural 2 Accident 5 Pending Investigation 1 Yes 2 No 24 hours after deeth. 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ot deeth (Item 23a) (Type, Print) 30. Nema end eddress of person who completed cause 157. Falender melliner 31. Dete liled (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death **Physician** ISABELLE VIRGINIA SHOWE 10, 1999 4c. County of Death 1999 DECEMBER 11:25 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign October 20, 1926 County Maryland 6 Sax 7. Age (In yrs. last birthday) 73 Yrs. **Funeral** Months Days 1 □ M 2 🖾 F 219-20-1346 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Pearl Street 21701 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Inspector Optical Company 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be John Floyd Morgan Myrtle Virginia Poffenberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Pnnt) 402 Pearl Street, Frederick, Md. 21701 Harvey I. Showe, Jr./Husband 20b. Place of Disposition (Name of cometery, cremetory or other place) Mt. Olivet Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Dec. 15, 1999 Frederick, Maryland 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home MQ0021 ord 106 East Church Street, Frederick, Maryland 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Adenocarcinoma WEEKS ESOPHAGEAL CANCER Months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): p Be Completed

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Futheral Director: After this certificate has been signed by the attending physician and completely filled in by the fundatidirector, page 2 should be deteched for use as the burnal-transit Division of Vital Records, P.O. Box 68760, edicai Certification: To

or 28a-f

Herrie 23a

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or has any Injury or other traumatic event.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Pert II. Other significant conditions of	entributing to death but not res	23b. Did tobacco uae co	ontribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown						
				24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Wes case referred to medical	26. Place of Deeth (Check only one)								
exeminer?	Hospitel: 12 Inpatient 2	ER/Outpatient 3		ne 5 ☐ Residence 6 ☐ Other (Specify)					
7. Menner of Deeth Detural 5 Pending Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occur	rred				
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	ome, ferm, street, fact fy)	28f. Location (Street end Number City or Town, Stete)	8f. Location (Street and Number or Rural Route Number, City or Town, State)					

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) A.Z. HEGAZÍ SOI TOLL HOUSE

HEGAZI, MD

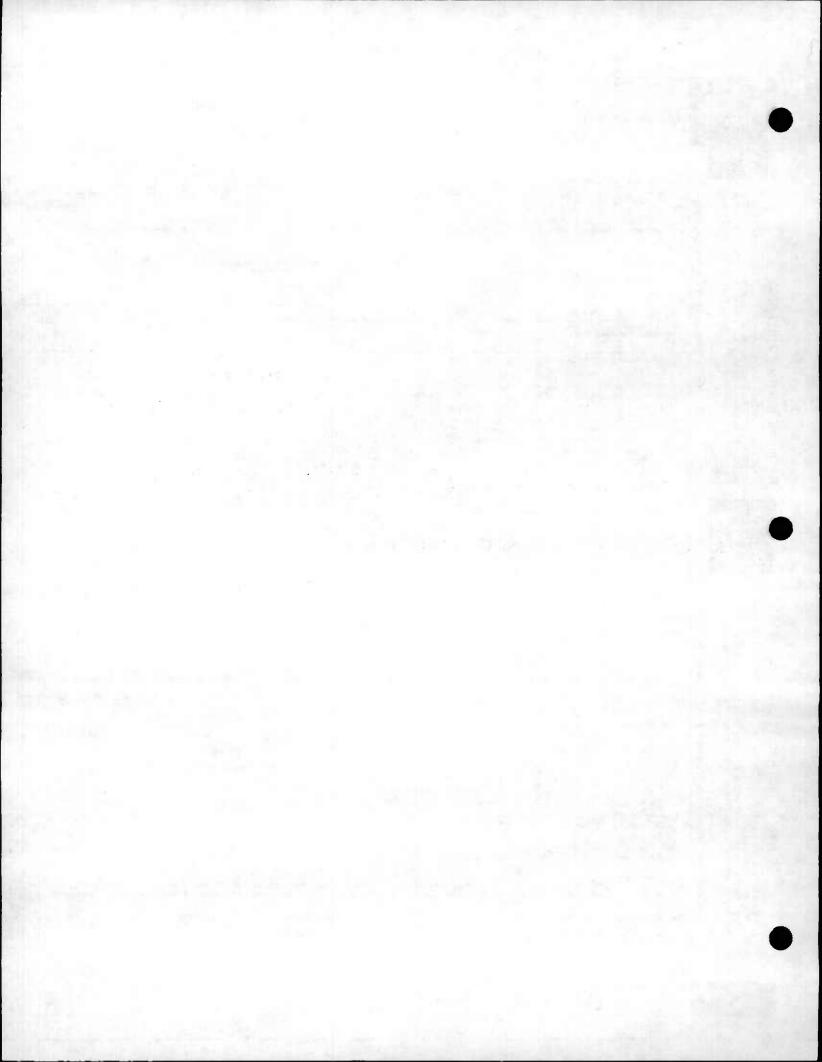
29b. Signetace and title of certifier

12-12-99 144184 FREDERICK MD 21701

29d. Dete signed (Month, Day, Year)

State Registrar

29c. License number

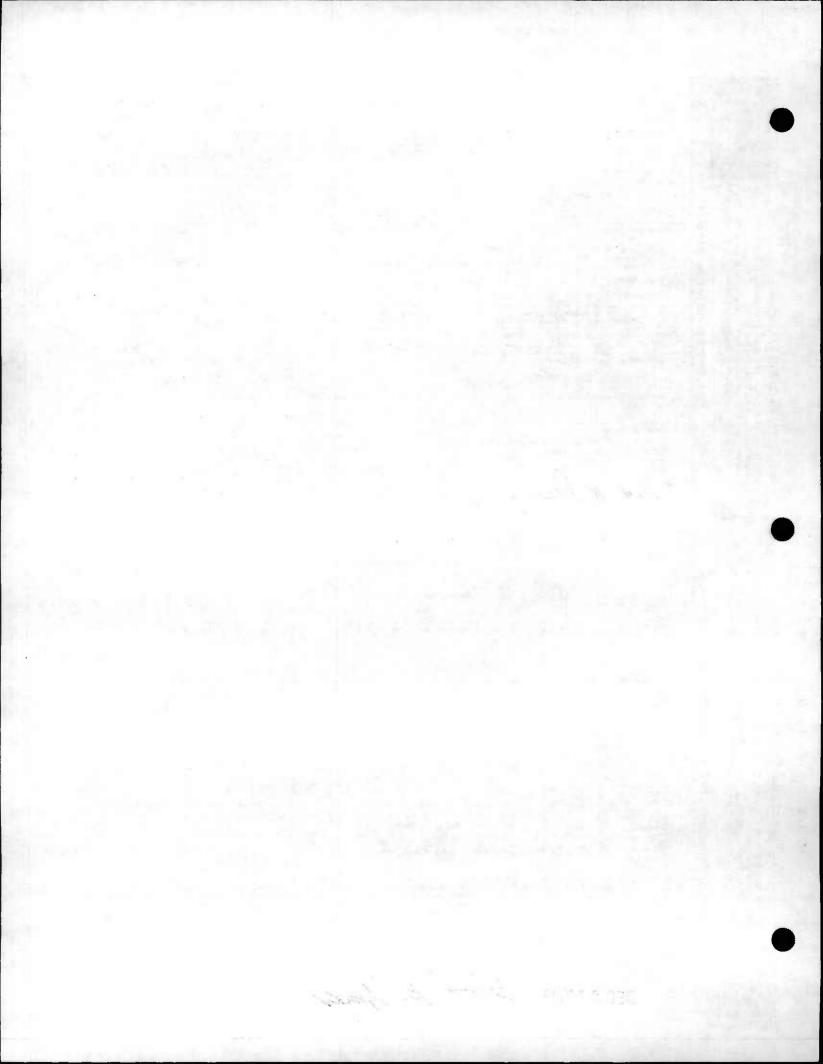


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certifica	ate of Death		Reg. No.	40866	
Bhualainn	1. Decedent's Nama (First, Middle, La	est)			2. Data of Dea Month		3. Tima of Death	
Physician /Medical	HARVEY	LEROY	STEVEN		ECEMI		999 1909	
Examiner	4a Facility Nama (If not institution, given		-= - [4b. City, Town, or	Location of Death			
(A)	PENINSULA REGIO	ONAL MEDICAL	CENTER	SALISE	BURY	WIC	COMICO	
Funeral		Dec -D-	Month	der 1 Year If Under 24 Hr ns Days Hours Min		h v. Year)	Birthplace (State or Foreign Country)	
Director	562-54-0374	1 🕅 M 2 🗆 F	9 Yrs.		February	12,1930	Michigan	
2	Usual Residence of Decedent 10a. Stata 10b. County	100	. City, Town or Location				404 1-14-02-1-2-2-	
arya en a							10d. Inside City Limits 1 ☑ Yas 2 ☐ No	
Be-I	Maryland Wicom	LCO	Salisbury					
with the Maryland a or 28a-f show the notified at	10e. Street and Number			Zip Code		10g. Citizen of W		
£ 23 £	406B Patrick Av			21801		USA		
Rome Purper	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13. Was De	cedent of Hispanic Origin? () pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, atc.)	14. Hace Black	- Amarican Indian, , Whita, atc.	
0 4 2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No N	Marines 10 Yes	2 No Specify:		Specify:	r.n. i b	
15-0020 n 72 hours at netural; or		Year or Dates:	16a. Decedent's U	aual Compation		16b. Kind of Bus	White	
T : [1] 등	(Specify only highest gr	ade completed)	(Give kind of life, DO NO)	work done during most of wo	orking	TOD. KING OF BUS	messinousity	
d within 7 glene.	Elementary/Secondary (0-12)	College (1-4or 5+)	Marine	Shirt Sail		U.S. Mi	litary	
be filed with that Hygiene. It was the than event, the the than event, the the than event, the the than the the than the the than the	17. Father's Nama (First, Middle, Last)	Hatine	-	ma (First, Middle,			
ylanc ould be fl Mental H arked out artic ever	James Robert Ste	even		Alice	Thelma H	arris		
Maryland 2 d 2 should be filed th end Menta Hygis T is marked other traumetic event.	19a. Informant's Name/Relationship (Type Print)	19h Mailing Addn	ess (Street and Number or R			State Zin Codel	
0 0 0 0	Laurel K. Etmans	***		Patrick Ave.,				
tore, Marylis ges 1 and 2 should to Health and Mer if ham 27 le marke or other traumatic	20a. Mathod of Disposition		b. Place of Disposition (/	Name of	Data	-	City or Town, Stata	
Baitimore, Normaline Pages 1 and Depertment of Health Important: If Itam 27 any Injury or other transce.	1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stata	cometery, crematory of		12/0/00			
Itin	4 Donation 5 Other (Special 21. Signature of Funeral Service Light		Salisbury Cr		12/9/99		oury, MD	
Bait Pemit. Depertrimportumpor	21. Signature of Furieral Service D	fessional Association						
	Keets R MA	ine		Snow Hill Rd.				
	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not enter the m	ode of dying, such as cardia	ac or raspiratory an	rest,	Approximata Intarval Batween	
Physician		Onset and Death						
/Medical Examiner	Immediata Causa (Final disease or condition resulting in death)	9 Days 9 days						
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executed n and tal-transit Examiner		b. 9EP91	5.				19 gay 9	
and I-tran	Sequentially list conditions,	Due to (or as a consequence of): C. RESP. Fai" LYRE-MELUAUICM. 7dly Due to (or as a consequence of): U.e.u. H/4 Hon.						
	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	C. RESP.	7acy 9					
ficate be physicians the buse the buse be	that initiated events resulting in death) Last	nHlat	on.					
E E E		d.						
BOX eath cert attending for use								
. 0 0 -	Part II. Other significant conditions of	ontributing to death but no	resulting in the underlyin	g causa given in Part I.	23b. Did t	obacco use con	tribute to the cause of death?	
	GUA		1 Yes 2					
w requires that the property of the property o			ROPERT OF				0.41 144 4 4 4	
The law requirete has been a page 2 should	DEMENH.	•			Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause			
has the mpl							of death? N/A_	
Con Page Con					1 D Y	as 22No	1 ☐ Yas 2 ☐ No	
Alta entific ector,	25. Was case referred to medical axaminer?				eath (Check only o	ne)		
hysic aldire of TO	1 Yas 2☑ No				Homa 5 ☐ Resid	lence 6 Othe	r (Specify)	
Affer th funeral	27. Manner of Death 1 2 Naturat 5 Pending	28e. Data of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	low injury occurre	d	
- 68:9 6	2 Accident investigation		M	1 ☐ Yes 2 ☐ No				
DIVISION I or Attanding after death. Director: After d in by the fune.	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide detarmined		At homa, farm, street, fact	ory, office	281. Location (S City or Tow		r or Rural Routa Number,	
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n 24 hound n 24 hound no Funer pletaly fill edical				ed at the tima, data and plac ion, in my opinion, death occ				
the H	one)	and manner stated.						
To the to	29b. Signature and title of certifier	1-		29c. License number			(Month, Day, Year)	
	> wang lu	19		D32014		12/7/94		
1.11	30. Nama and address of person who	completed cause of death	(Item 23a) (Type, Print)	D320/4 5048 Seli-	1011-1-	16 2 10	- H	
IVATO	MAHBY MOON!	RA 116 U	11/F021954	5045 7001-	sury a	112 618	7	
State	31. Data filed (Month Par Yang) QQ	- On Allia minters sin &						

562-54-0374

HARVEY Steven



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State of Maryland / Department of Health and Mental Hygiene Q Q 40867 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day **Physician JOSEPH** SPARROW December 4, 1999 0242 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year Months Days 6. Sex 1 M 2 □ F If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) APRIL 2,1925 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 224-20-0255 Yes Director 74 VIRGÍNIA Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location ed other than "natural", or items 23s or 28s-f show event, the Medical Examples round be notified at 10d. Inside City Limits 1X Yes 2 No Director MARYLAND WICOMICO SALISBURY 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Country? 402 HAMMOND ST. 21804 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Adjust Forces?

1 △ Yes 2 □ No ARMY
If Yes, Give
Yeer or Detes: WWII Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Sfetus of Hygiene.

of Hygiene.

other than "netural", or ite 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 ELECTRICIAN SELF-EMPLOYED permit. Peges 1 and 2 should be fillet.
Department of Heelth and Mentel Hygi important: if item 27 is marked other any injury or other traument. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) **JOSEPH** Τ. SPARROW ANNIE BONNEVILLE 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SPARROW - WIFE 402 HAMMOND ST. LILLIAN L. SALISBURY, MD 21804 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State SPRINGHILL MEMORY GARDENS 12/8/99 4 ☐ Donetion 5 ☐ Other (Specify) HEBRON, MARYLAND 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility 705 E. MAIN ST. 23a. Perl1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 Approximete Intervel Between Onset end Deeth **Physician** memora Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examiner sician and burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): 68760. Physician/Medical Due to (or es e consequence of): Box (P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown p been sig 24b. Were eutopsy findings eveitable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes No 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending death. 1 Tyes 2 No investigetion 2 Accident we Hospital or Attend n 24 hours after death we Funeral Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier Medical To the Function (Check only one) To the To the To the F 29b. Signeture and fittle of certifier 29c. License number 29d. Dafe signed (Month, Dey, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) + IVA Riversile 32/Registrer's Signeture State

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SPARROW

JOSEPH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Clockett 30 Pm 30 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williams 464 EAST W. LOMICO STARET Stlisbule If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Data of Birth (Month, Day, Birthplace (Stata or Foreign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 10M 2DF 219-36-574 62 Yrs VA Director Usual Rasidanca of Dacedant 10a. State 10c. City, Town or Location 10d. Inside City Limits pamit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 ehow any injury or other treumatic event, the Medical Examinar must be notified at 1 THES 2 No Director 160 MICO Alishar 10g. Citizen of What Country? Of. Zip Code Williams 404 EAST 21801 USA Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced AMBRICAN 186 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working iffa. DO NOT use retired) 16b. King of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) SERVICE 12 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden \$umame) Be SAVAGE SAVAG OUISE E Mudol Informant's Name/Palationship (Type, Pnnt) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City of Town, Stata, Zip Code) VALENTINO Md. 21044 Columbia SAVAC WoodCuttER 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Durial 2 Cramation 3 Ramoval from Stata MEM 4 ☐ Donation 5 ☐ Othar (Specify) ACLES SHIRBAR 21. Signatura of Funaral Service Licent 22. Nama and Address of Facility Hon BNN 15Abellit Approximata Intarval Between Onset and Death 23a. Part Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner 11/46 unloc Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or injury that initiated evants rasulting in daath) Last burial-tran and Dua to (or as a consequence of): 68760 Physician/Medical the Dua to (or as a consequence of): Box P.O. | Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown bengis be ed b Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital I Attending Physicien: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of Injury 28c. Injury at Work? 1 Natural 5 Pending 1 TYas 2 No death. invastigation 2 Accident Director 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Hospital or Att
 24 hours after d
 Funeral Direct
 letaly filled in by 4 \ Homicida 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. completaly (Check only one) one: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of ceptifie 29c. License number 29d. Data signed (Month, Day, Year) DZYGFC ws

Registrar **DHMH 16 Rev 6/95**

State

30. Nama and address of person who compl

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ext

Kol 31. Data filed (Month, Day, Year) Riverste

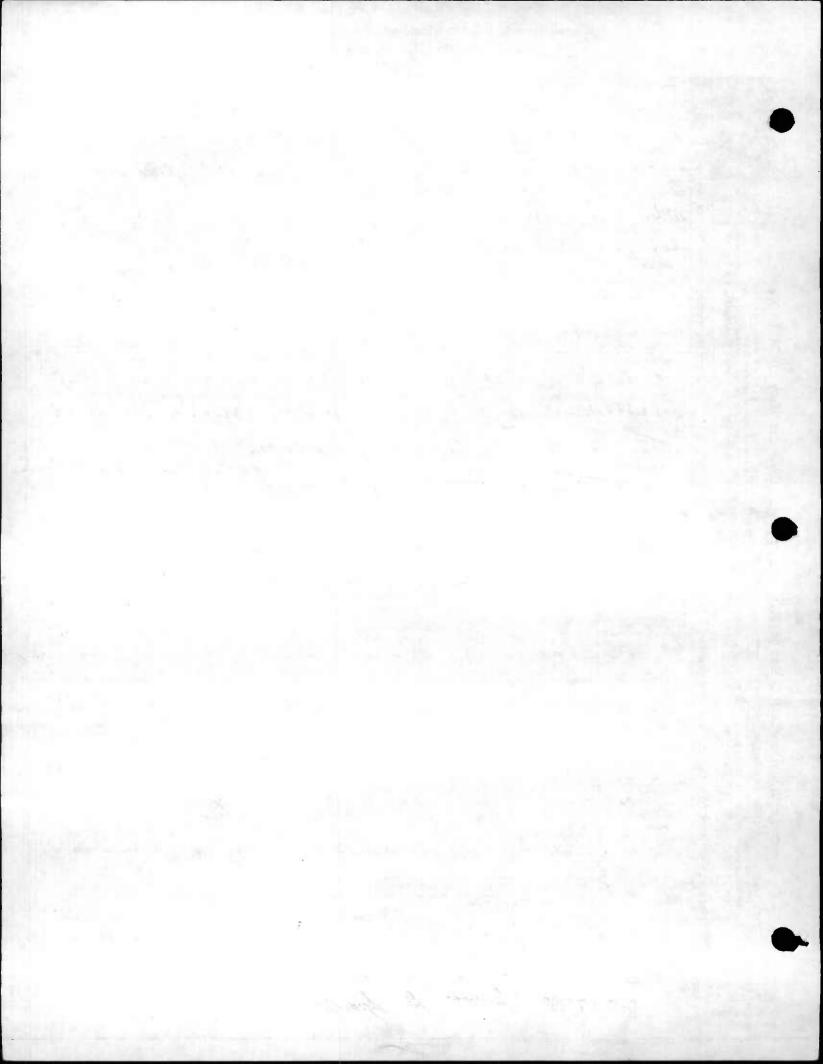
BIOI Salisbury Md. 21501

used causa of death (Item 23a) (Type, Print)

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32. Registrar's Signatura

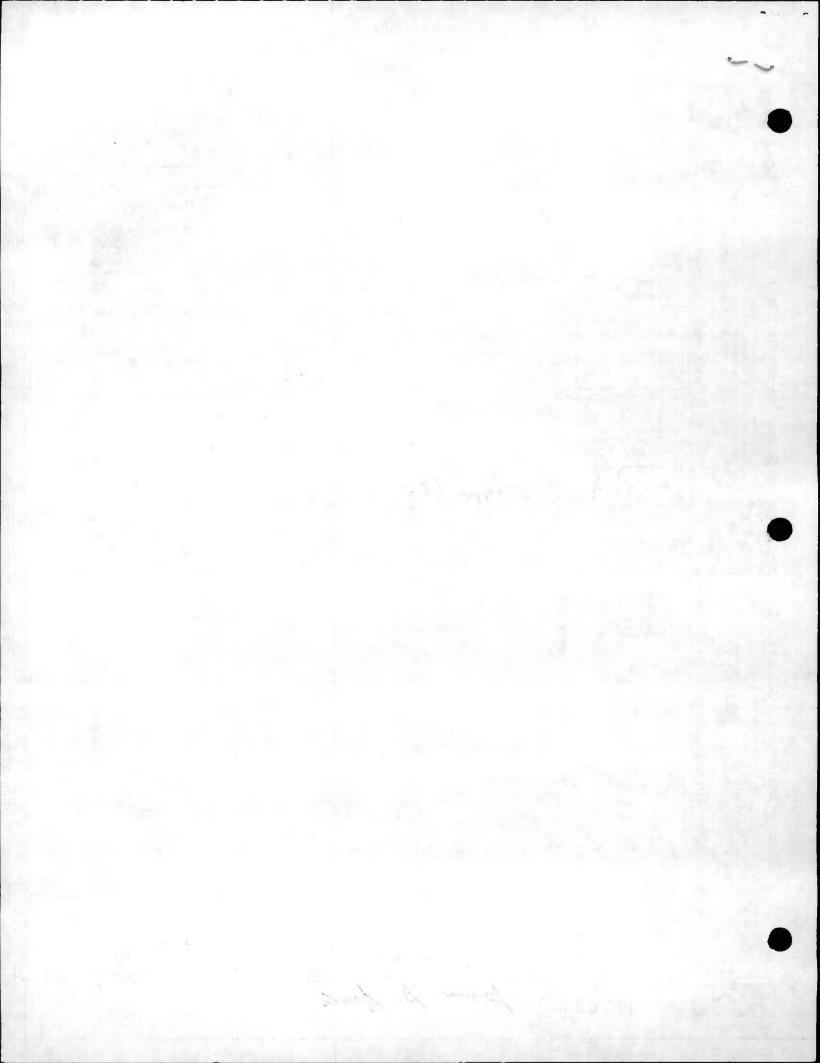
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Amended # 8 Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. WCHD bbk 12/02/99 State of Maryland / Department of Health and Mental Hygiene July 1, 1909 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Day Year **Physician** December 1, 1999 Pation of Death 4c. County of Death Matthews Small /Medical MA 00:8 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1909 9. Birthplaca (State or Foreign Country)
July1, 1990 VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2 F Yrs 90 Director 212-03-0914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2□ No Directo MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 200 CIVIC AVE. 21804 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married b Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) OWNER/ OPERATOR SHOE STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hy ant: If Nem 27 is marked oth lury or other traumatic event TRVING MATTHEWS PEARL W. THOMAS 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS F. JOHNSON, JR. 128 E. MAIN ST. SALISBURY, MD 21803-0506 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State ortant: If It 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State ASSAWOMAN U.M. CEMETERY 12/6/99 ASSAWOMAN, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa 22. Name and Address of Facility Sunera 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 ise, or complications their clused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, b. List only one cause on each line. Approximete tntervat Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner la The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. Physician/Medicai Due to (or as USB as signed by the et P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings svailable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2€ No Other: 4 Armsing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Waturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 H. Robins M.D Jilliam 1,4h 31. Dete filed (Month, Day, Year) State DEC 0 2 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** December 11 1999 10:18 p.m. NANCY **JEAN** SUCHOCKI /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Dunkirk 4021 Chaney Cove Court If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Apr. 7, 1913 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 1□ M 2 F Bellevue, PA 167 05 1001 86 **Director** Usuel Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at Dunkirk 1 ☐ Yes 2 No Calvert Maryland Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 20754 USA 4021 Chaney Cove Court Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. Was Decedent Ever in U,S. Armed Forces? Pages 1 end 2 should be filled within 72 hours after nent of Health and Mentel Hygiene.
int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2X No Specify: altimore, Maryland 21215-0020 Specify: white à 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Esther Graham Curtis Myers Jean 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) same as # 10 above Bonnie Jean Carver/ daughter 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete 12-13-99 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 s that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, so on each line. 23a. Pert1. Enter the diseese, or comp Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) Chance Obstructue Pulmora /Medical Examiner Examiner thet the death certificate be axecuted physician end is the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Physician/Medicai Due to (or es e consequence of) USB as 1 ò signed by the e 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by should I 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 certificate has 1 Yes 2 No 1 Yes ENNo or Attending Physician: funeral director. 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home → Residence 6 ☐ Other (Specify) 1 Yes 2 No P After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation Maturel i Director: Affi d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steled.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29e. Certifier completaly (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Yeer) D33 123 30. Name end eddress of person who all 5 duse of deeth (Item 23e) (Type, Print) Jonathan Lowenthal, M.D. 10845 Town Center Blvd., Dunkirk, MD 20754

State Registrar

31. Dete filed (Month, Dey, Year)

32. Registrer's Signature

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ordered Labor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Knefler 14, Joseph Taussig Jr. Dec. 1999 3:19 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 28, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Min Yrs. 212-36-9087 Director Rhode Island Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ty Yes 2 □ No Directo Maryland Anne Arundel Annapolis filed within 72 hours after death with the M Hygiere. other than "natural", or itema 23s or 28a-f ent, the Madical Examiner must be notifie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 400 Ridgley Avenue 21401 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 13 Yes 2 □ No If Yes, Give Year or Dates: 37—54 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indien Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2√ No Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other th any injury or other traumatic event, the once. U.S. Navv 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph K. Taussig, Sr. Lulie Johnston 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Taussig/Wife 400 Ridgley Ave. Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metropolitan Crematory 12-15-99 Alexandria, VA. 4 Donation 5 Other (Specify) 21. Signature of Funerel Se 22. Neme and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street. Annapolis, Md. 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical wheel beconing Examiner Due to (or as a consequence of); Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vitai Records. Ś cate has been sign, page 2 should b 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificate has 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of call 29c. License number 29d. Date signed (Month, Day, Year) ad cause of death (Item 23a) (Type, Print) Avenue FURLOW State

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Physician December 1999 0850 TRUITT PATRICK KING /Medical Facility Neme (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO SALISBURY Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplaca (State or Foreign **Funeral** Months Days Country) MARYLAND 216-38-8312 Yrs 60 NOV. 20,1939 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No WICOMICO SALISBURY Director MARYLAND or 288-1 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21804 #108G 238 U.S.A. 228 CANAL PARK DR. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: NAVY Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or Items 11. Marital Status 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AIRBORNE EXPRESS COURIER 12 permit. Pages 1 and 2 should be life. Department of Health and Mental Hyp. Important: If Item 27 is marked any Injury or other to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RAYMOND KING TRUITT ELOISE PATRICIA DOODY 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) #108G SANDRA H. TRUITT - WIFE SALISBURY, MD 21804 228 CANAL PARK DR. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12/11/99 SALISBURY, MD PARSONS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 705 E. MAIN ST. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of) been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Yunknown þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Attending Physician: The law 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ДООА Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation death. 1 □ Yes 2 □ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) in 24 hou... the Funeral Dire... In filled in by 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contille

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

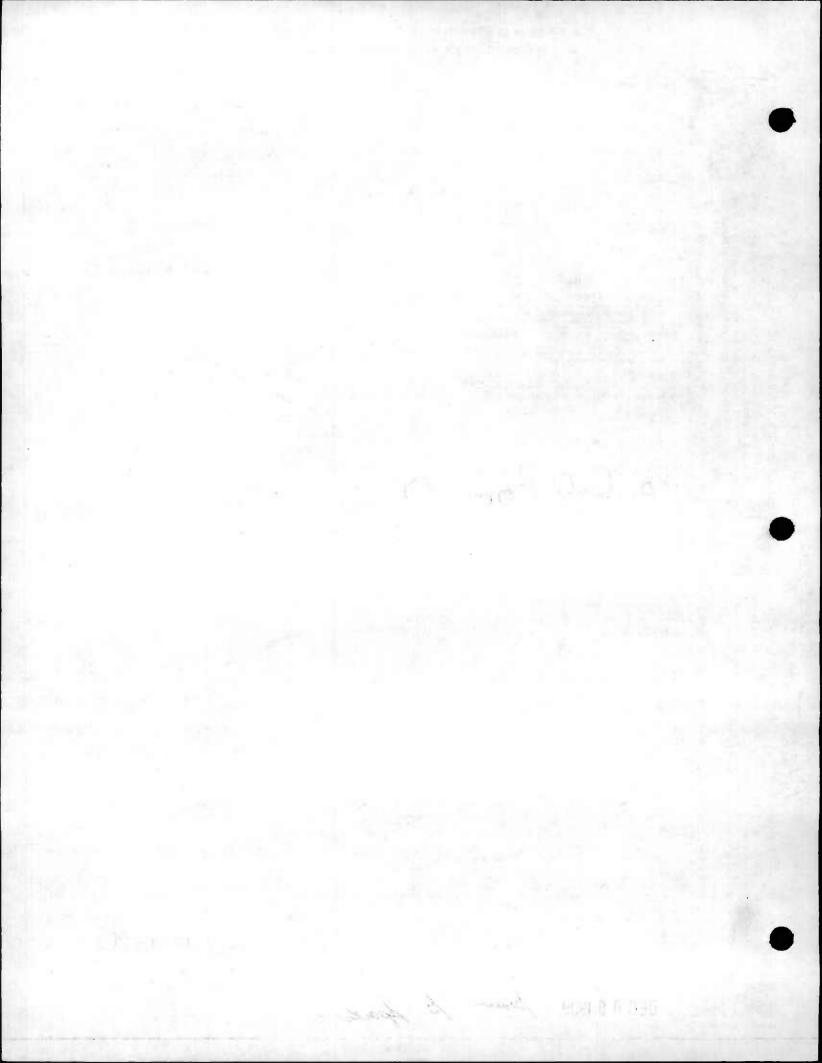
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BYET LEVY M 31. Date filed (Month, Day, Year)

DEC 0 9 1999

PRMC

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40873 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HERBERT **BENJAMIN** TRICE December 10 1999 7:30 p.m. /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chesapeake Woods Center Cambridge Dorchester | Min. | 8. Data of Birth (Month, Dey, Yeer) | April 17 1911 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days 12 M 2 F 88 217-10-8646 Director Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at MD Dorchester Cambridge VOTES 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 525 Glenburn Ave. 21613 U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) TINEVer Married 2 Married 1 Yes 2 No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry a filed within 7 il Hygiene. other than "n Elementary/Secondery (0-12) College (1-4or 5+) custodian garment mfg. company permit. Pages 1 and 2 should be this Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Eugene Cleveland Trice Lula Bradley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 517 Academy St. Cambridge, MD 21613 Gladys Woolford - sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removal from State Dorchester Memorial Park 12-14-99 Cambridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home PA 21. Signature of Funeral Service Licenses 700 Locust St. Cambridge, MD 21613 23a. Part1. Enter the disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical · Preumonia weeks Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not ba determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed been signed by the a should be detached certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; f

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and menner es steted. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Yeer) December 13,1999 MA 000 53198

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

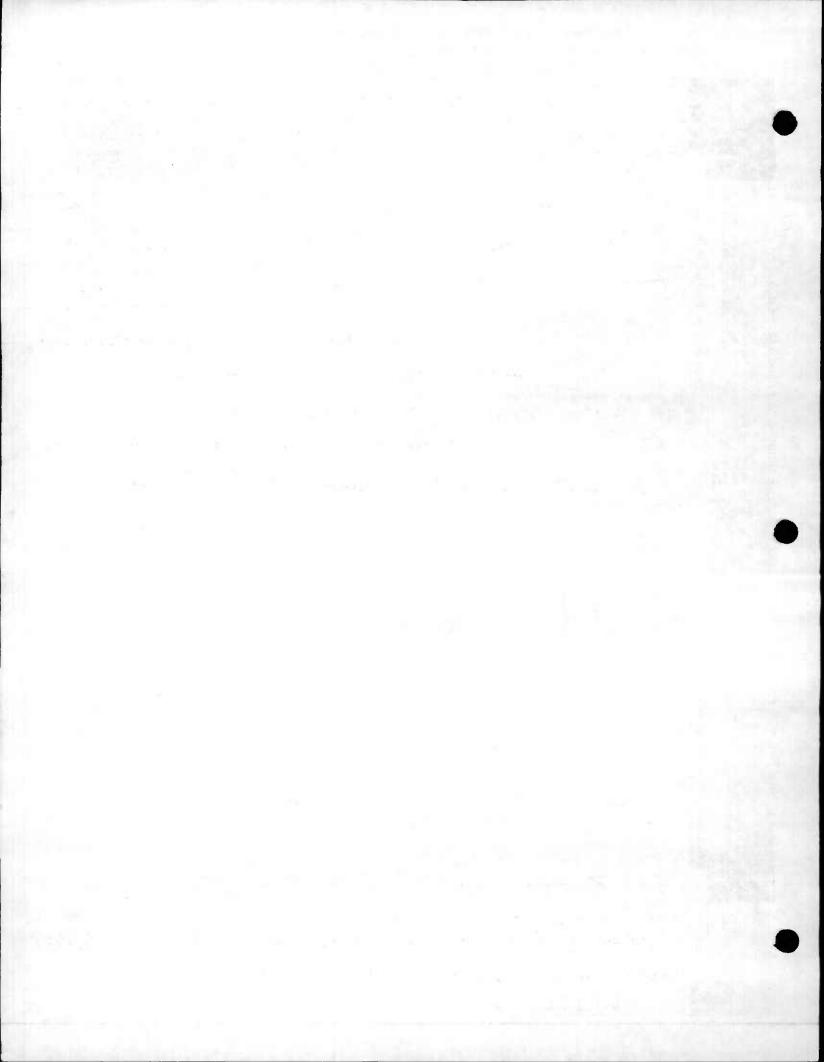
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503 BYRN ST suite 1 CAMbridge, MD 21613 MARKE VelARde 31. Date filed (Month, Dey, Year)

Registrar

Medical



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

nysician	Decedent's Name (First, Middle, Last)							2. Dete of Deeth Segretary		
Medical		Luellen	P.	Tes	schner			Decembe	er 12, 19	99 2:30 P
xaminer	4s Fecility Name (If not institution, give street and number)						4b. City, Town, or Location of Death 4c. County of Deeth			eeth
		Maple Ridge Center				WII - 4 - 4	Rockvi		Montg	-
neral ector	5. Social Security 252-20 Usual Residence	-8376	6. Sex 1 □ M 2 □ F	7. Age (In yrs.		H Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Dey Sept. 24	Year) 9.1 1, 1917 G	Birthplece (State or Fore Country) BLOLGLA
thin 72 hours after death with the Maryland an *natural*, or hams 23e or 28e-f show Medical Examiner must be notified at plieted by Funeral Director	10a. State	10b. County		10c. Cit	y, Town or Loca	ation				10d. Inside City Lim
	Maryland	Mont	gomery		Rockvil	00				1 Yes 2
	10e. Street and N		gomety		RUCEVAL	10f. Zip Code		1	0g. Citizen of What	Country?
	15908 Ma	anle Did	log Ct		100	2085	3		USA	170
	11. Marital Status		12. Wes Dec Armed Fo	2 X No			fispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Bleck, W	merican Indien, Thite, atc.
a pe		15. Decedent			16a Decede	nt's Usual Occur	ation		16b. Kind of Busine	
r, the Medical Completed	(Sp	ecify only highes	st grade completed)		(Give kii	nd of work done NOT use retire	during most of work	ing	TOD: THING OF DOGING	ournousky
The o	Elementary/Sec 12	condary (0-12)	College (1-4or 5+)	Secret	้าสาน			DuPont	
h 27 is marked off n 27 is marked off her treumatic even To Be	17. Father's Name	e (First, Middle, (Last)		, 500.00	NO COJ	18. Mother's Nam	e (First, Middle, I		-1
	Lewis	el Craft	ift Gladys I			Irene Mu	rphu			
	19a. Informant's	Name/Relationsh	hip (Type, Print)	3				1 1	e, Zip Code)	
	James I	Purvis/S	Son		1700	Empress	Pl. Cha	rlottsui	PPO VA	22911
	20a. Method of D		4.4	20b. F	Place of Disposit	tion (Name of story or other ple	20)		20c. Location - City	
70		2 Cremation 5 Other (Sp	3 ☐Removel from	Stete			1	2 16 00	Names b 1	0000000
in a				INCL				2-18-99	Newark, L	rexaware
Aug GDG	21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P. A.									
17.11	Xu	MXZ.L	Hood	ull			Rising			
- 12	23a. Pert1. Enter shock, or he	eart tailure. List	compositions that conly one cause on a	caused the deet sech line.	h. Do not enter	the mode of dyir	ng, such as cardiac	or respiratory err	est,	Approximate Intervel Between Onset end Death
cian	Immediate Cause (Final disease or condition resulting in death) a. Prev monitary Due to (or as a consequence of):									
dical liner										5 duys
5										
iei-transit Examiner			b							1
Xar	Sequentially list of any, leading to	conditions, immediate		Due to (c	or es a conseque	ence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									1
	Cause (Disease	that initiated events resulting in death) Last Due to (or es a consequence of):								
de bur	cause. Enter Un Cause (Disease of that initiated ever resulting in death) Last								
as the bur	cause. Enter Un Cause (Disease) that initiated ever resulting in death) Last	d							
as the bur	resulting in death) Last	d							1
as the bur	Part II. Other sign	n) Last	d		ulting in the und	erlying cause giv	ven in Pert I.			
as the bur	Part II. Other sign	n) Last	d. one contributing to di		ulting in the und	lerlying cause giv	ven in Pert I.			
be deteched for use as the burbur by Physician/Medical	Part II. Other sign	n) Last	^		ulting in the und	lerlying cause giv	ven in Pert I.	1 U Y	98 2□ No 3□	Probably 4 Unkr
be deteched for use as the burbur by Physician/Medical	Part II. Other sign	n) Last	^		ulting in the und	lerlying cause giv	rên in Pert I.		n eutopsy 24	Probably 4 Junkn 4b. Were eutopsy finding eveilable prior to
be deteched for use as the burbur by Physician/Medical	Part II. Other sign	n) Last	^		ulting in the und	lerlying cause giv	ven in Pert I.	1 □ Y	n eutopsy 24	Probably 4 Junkn 4b. Were eutopsy finding eveilable prior to
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director, page 2 should be deteched for use as the bur To Be Completed by Physician/Medical	Part II. Other sign A/Z	nificant condition Mei Mer	's Dise	rase	ulting in the und		26. Place of Deet	1 Y	n autopsy 24 ned?	Ab. Were autopsy finding eveilable prior to completion of causa of death? 1 Yes 2 No
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Registrar DHMH 16 Rev 6/95

State

DENNIS J CHODNICKI, ND.

DEC: 0 1 1999

31. Dete filed (Month, Dey, Year)

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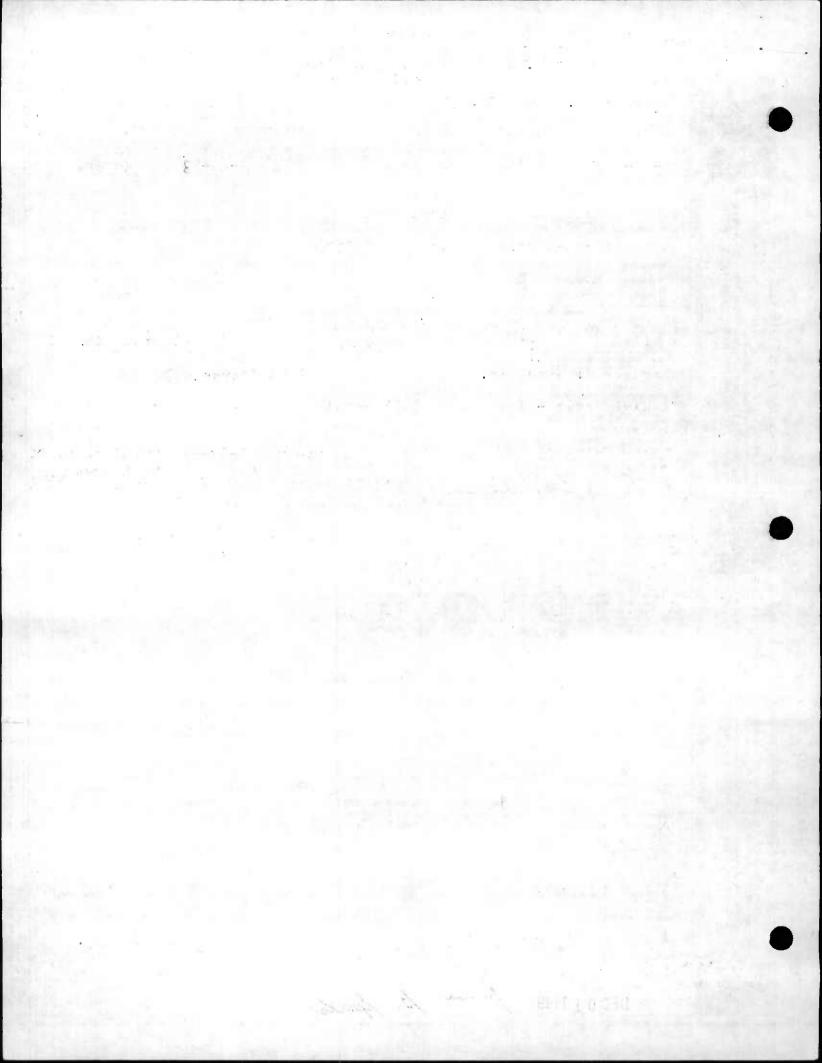
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32. Régistrar's Signatura

400 Enstern SHORE DR. SALISBURY, MD. 21804



		Decedent's Name (First, Mide	tle, Last)			Cer	tificate of	Death	2. Date of Deat		3. Time of Deeth	
Physic /Medi Exami	cal	al GILDA FRANCIS WATKINS						4b. City, Town, or 1	Month Day Year Dec 8 1999 1730 Location of Death 4c. County of Death			
Exami	ner	The Memoria						Easton				
Funeral Director		5. Social Security Number 135-20-9862	6. Sex	_		est birthday) Yrs.	If Under 1 Yee Months Days	r If Under 24 Hrs.	Hrs. 8. Date of Birth 9. Birthplece (State or For			
within 72 hours after death with the Maryland and than "natural", or thems 23a or 28a-f show he Madical Examine must be neutragation ompleted by Funeral Director	_	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location								10d. Inside City Limit		
28e-1	Director	MD . QUEF	N AI	NNE	СН	ESTER	10f. Zip Code		10	na Citizen of V	What Country?	
30 00			. D. D.				101. 2.10 0000	21610				
is after beart with the Marylar I', or ferms 23a or 28a-f show to the construction	by Funeral	135 EDGEWOO 11. Marital Status 1 Never Married 27 Ma 3 Widowed 4 Divorce	2. Was Decedent Armed Forces? 1 Yes 2 H Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Rac	ice - American Indian, ack, White, etc.			
atura		15. Decede		ation		16a. Deced	ient's Usual Occu	pation	17	16b. Kind of Br	usiness/Industry	
D D	Completed	(Specify only high Elementary/Secondary (0-12)	est grade	College (1-4or 5	5+)	LABC	OO NOT use retir			SEA	EAFOOD	
d other	Be	17. Fether's Neme (First, Middle	, Last)	La rent				18. Mother's Name (First, Middle, Maiden Sumem		ne)		
Men	2			NGTON		MYRTLE				COULBURN		
4 0 0 0		19a. Informant's Neme/Reletion	ship (Type					et end Number or Ru				
nent of Health rit: If item 27 iry or other tr		ALICE WILL 20a. Method of Disposition 1 Burial 2 Cremation	3 □Re		20b. Pl	aca of Dispos metery, cren	sition (Neme of netory or other pl	ece)	Date	20c. Location -	City or Town, State ESTER, MD.	
Department Important: any injury		WATKINS MEM. CEMETERY 12/15/99 CHESTER, MD. 21. Signeture of Funeral Service Licensee DASHIELL FUNERAL SERVICES										
-		23a. Part1. Enter the disease, of	r complic	ations that caused	I the death			OVER ST			21601 Approximate	
hysician		shock, or heart tailure. Lis	t only one	cause on eech lin	10.	. Do not dritt	or the mode of dy	ing, socia as cardia.	or respiratory and	,	Interval Between Onset and Death	
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a.	Pneu	mon	ia	de la la				10 day	
	١٥	Due to (or as a consequence of): At which they failure							In Sau			
nd nd name it	Examiner	Sequentially list conditions	f b.			as a conseq	dence of):	NAC			10 days	
sician and burial-transit	al Exa	Cause (Disease or Injury								10 dass		
attending physical for use as the t		thet initiated events resulting in death) Last Due to (or as e consequenca of): d. Acute on Curvuic reval taile						1,11	Trans.	10 day		
e attending phys	an		d.,	- OCU	2 00		00110 10	and jac	more		1	
y the	y Physician/Medic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Pulmbury Edlurk							23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Onknow			
pinou	Completed by)						24a. Wes e		24b. Were autopsy finding evailable prior to completion of cause of deeth?	
<i>E</i> 9	E O								1 🗆 Ye	s 25 No	1 ☐ Yes 2 ☐ No	
	Be	25. Was case referred to medic examiner?							oth (Check only on	e)		
this certific ral director,	2	1 ☐ Yes 2 SONo	Но	spital: Inpatie		ER/Outpatien	I SLI DON		ome 5 Reside			
ath. r: After ne fune	Certification:	Z L / Noolddrit	igation	28a. Date of Injui (Month, De)	late of Injury Month, Dey Year) 28b. Time of 28c. Injury at Work? Injury M 1 Yes 2 No			28d. Describe how injury occurred				
i Die		3 Suicide 6 Could deter	mined	28e. Place of Inju- building, etc	ury - At hor c. (Specify	me, farm, stre	eet, factory, office		28f. Location (St City or Town		ber or Rural Route Number,	
24 hours Funeral etely filled	edical	29a, Certifier 11X Certify (Check only one) 2 Medica	ng Physic Examine	cian: To the best of er: On the basis of and manner sta	of my know exeminati	rledge, deeth on and/or inv	occurred et the restigetion, in my	time, date and place opinion, death occu	, and due to the ca rred et the time, de	ause(s) end ma ete end plece,	anner as steted. and due to the ceuse(s)	
within To the	2	29b. Signature and title of certific	er	and mariner Sta			29c. Licer	nse number	2	9d. Date signe	d (Month, Dey, Year)	
- s ⊢ õ		5	DS.			1-19		6020		12/0	1/99.	
		30. Name and address of person SYED I. Al						E. EASTO	N.MD.21	601		

DHMH 16 Rev 6/95

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Physician	ı
/Medical	ŀ
Examiner	ľ
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Funeral Director

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Helen Wilson

21215-0020 filled within Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is merked other any Injury or other traumetic events. Saltimore,

Physician /Medical Examiner

for use as the burial-tran The law requires that the death certificate be execu should be det page 2 has certificate Attending Physician: funeral director, After this ne Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the fur

P.O. Box 68760,

Records.

Division of Vital

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dev Month HELEN TOWERS WILSON 9, 1999 Dec 1425 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth The Memorial Hospital Easton Talbot 8. Dete of Birth (Month, Dey, Year) JULY 4, 1911 If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplece (Stete or Foreign Days 1 M 2 K F 88 MARYLAND Yes 374-38-3729 Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No TALBOT MARYLAND EASTON 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? à 501 DUTCHMAN'S LANE, APT. 311 21601 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 VETERANS ADMINISTRATION SOCIAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be THOMAS HOUSTON TOWERS BERTIE MAE ADAMS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GEORGE E. WILSON / HUSBAND 501 DUTCHMAN'S LANE, APT. 311, EASTON, MD. 21601 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) CHESAPEAKE CREM. CTR 12-11-99 CHESTER, MD. 21619 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME Joseph M. Ostrowshi 200 S. HARRISON ST., EASTON, MD. 21601 Approximate tritervel Between Onset end Death 23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Respiratory Failure 4 Days Due to (or as e consequence of) Pleural Effusion 8 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): 13 Years Cancer Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Y Y00 2 □ No 3 Probably 4 Unknown Lower Gastrointestinal Bleed þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 1 ☐ Yes 2 No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 So, Washington St. Easton, MD 21601 Rachel Burdick MD

State Registrar

31. Dete filed (Month, Day, Year)

DEC 1 4 1999

completely

within 2 To the

DHMH 16 Rev 6/95

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** MARCIANNA WOOD December 14, 1999 9:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Nov. 26, 1941 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs. 58 220-36-8833 Director Maryland Usuat Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle Department of Health and Mantal Hydens. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show shipling or other traumstic event, the Madical Examinal must be notified as anse. 1 Yas 2 No Director Emmitsburg Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 530 West Main Street 21727 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whita, atc. 1 □ Never Married 2 □ Married Baltlmore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 🏋 Divorced White Completed 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Screen Printer Transtech 12 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fsther's Nama (First, Middla, Last) Ralph Singleton Falconer Alice Elizabeth Miller 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Donna J. Shores (Daughter) 530 West Main Street, Emmitsburg, Maryland 21727 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) New St. Joseph's Cemetery 12/17/99 Emmitsburg, Maryland 22. Nama and Addrass of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MARYLAND 21788 Approximata tntarval Batween Onsat snd Daath Do not antar tha moda of dying, such as cardiac or raspirstory arrast, 23a. Part1. Enter the dies shock, or heart fally Physician Immediata Causa (Finat disease or condition resulting in death) /Medical Breast Cancer Metastatic Examiner Dua to (or as a consequence of): Physician/Medical Examiner To the Mospital or Attanding Physician: The lew requires that the death certificate be associated within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be detached for use as the burish-transit Sequentially fist conditions, if any, leading to immediafa cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of): P.O. Box 68760. Dua to (or as a consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records. þ 24b. Ware autopsy findings sysilabla prior to Completed 24a. Was an autopsy complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa refarred to medical axaminer? å 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Nsturaf 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as ststed. (Check only one) 2 Medical Examiner: On the besis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 12-15-99 D43091 30. Name and address of person who completed casse of death (Itam 23a) (Type, Print) 801 Toll House Avenue, Frederick, Maryland 21701 Saeed A. Zaidi, MD

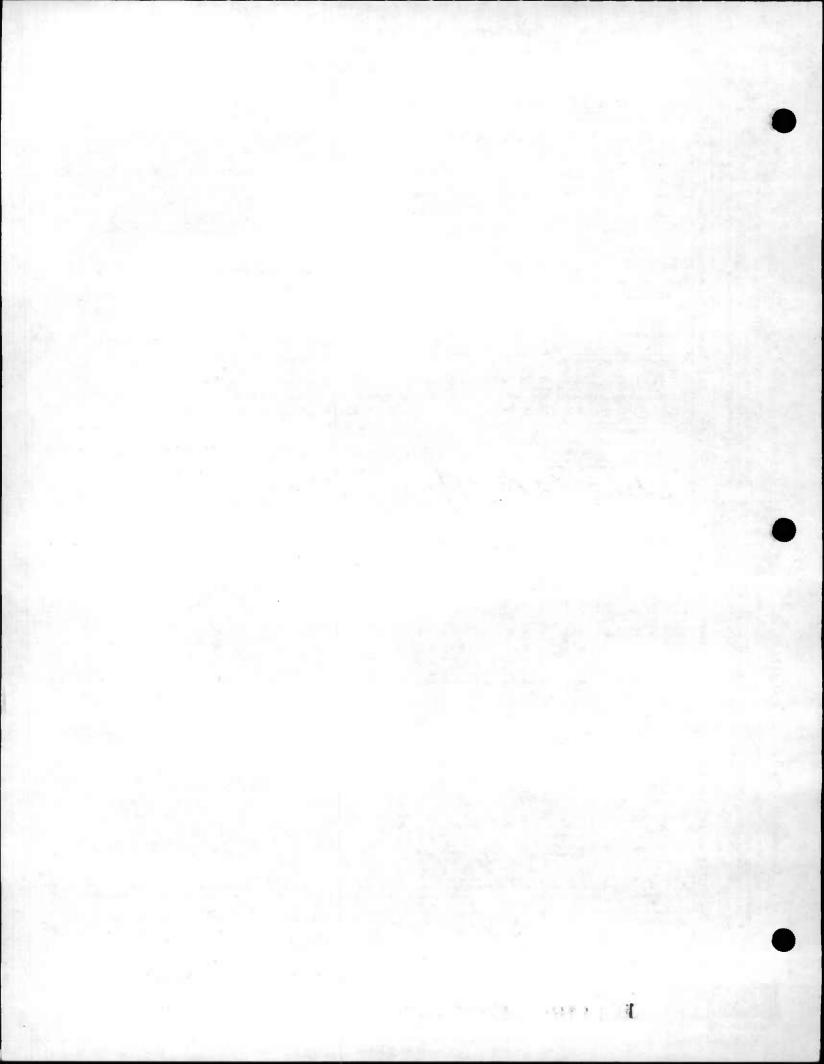
State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

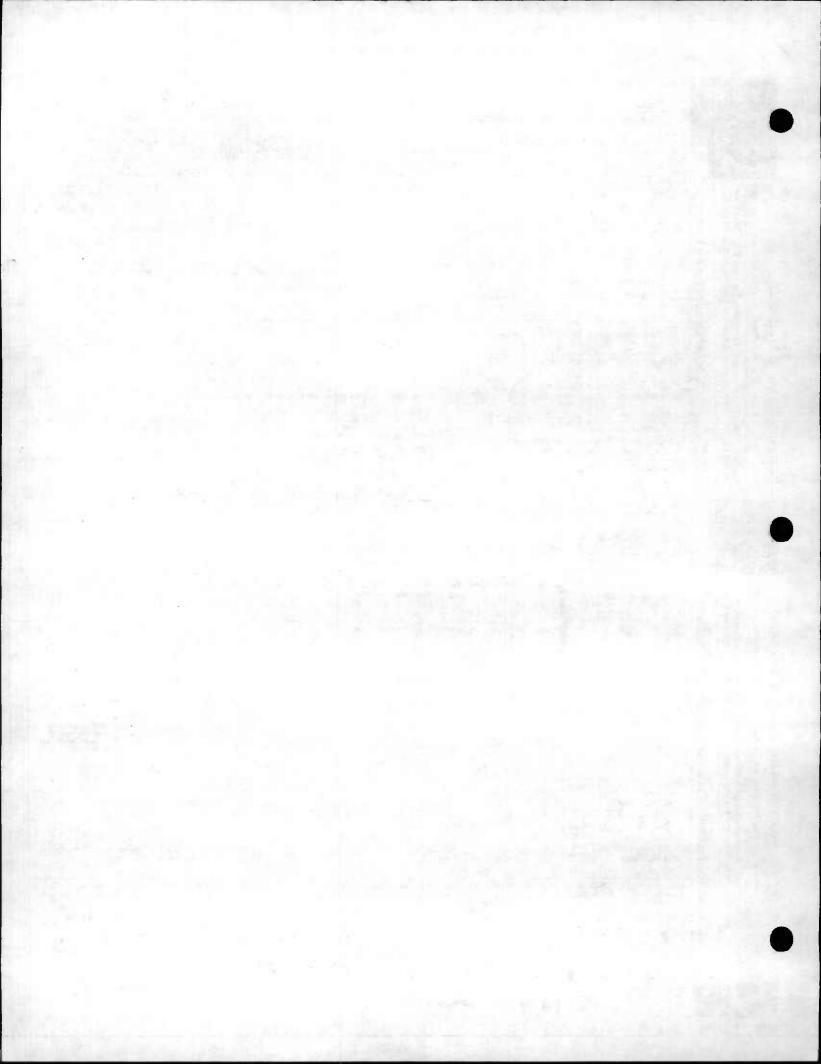
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32 Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Physician /Medical	GEORGE A WILLARD						r 12, 1	999	4:20 AM		
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Funeral			(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year)	9. Birthpla	ace (State or Foreign		
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7	Usual Residence of Decedent										
ayte and a	10a. Stete 10b. County		10c. City, Town or	Location				10	d. Inside City Limits		
with the Maryland a or 28a-f show be notified at Director	Maryland Freder	rick	THurmont	_					1 ☐ Yes 2 No		
9 22 B	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Counti	ry?		
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frer death frer death inser must	11. Marital Status	12. Wes Decedent Ev	ver in U,S. 13	B. Wes Decedent of H If Yes, specify Cub	lispanic Origin? (S			e - America	n Indien,		
hours after hours, or its at Examine		Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		1 ☐ Yes 2 ☒ No		o Hican, etc.)	Specify	ck, White, el whi	white		
O o man be	15. Decedent's	Education	16a, Dec	edent's Usual Occur	pation		16b. Kind of Bu	usiness/Indu	istry		
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Merital Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by 8	(Specify only highest g	rade completed)	(Gir	re kind of work done DO NOT use retire	during most of world)	king					
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State	31. Dete filed (Month, Dey, Year)	32. Registrer	mon	no	bar.						



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day 4b. City, Town, or Location of Death 4c. County of Death Samual Parry Watson 7:30 PM 4a Facility Nama (If not institution, give street and number) Salisbury Center: Genesis ElderCare Salisbury, MD Micomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Hours 10XM 2□ F 230-14-1048 83 Yrs. Feb 22, 1916 Usual Rasidence of Decedent 10a Stata 10b Counts 10c. Cftv. Town or Location 10d. Inside City Limits MD Wicomico 1 Yas 2 □ No Salisbury 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 702 Taylor St. 21801 U.S. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or Noti Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Laborer Poultry 18. Mothar's Nama (First, Middle, Meiden Sumame) 17. Fathar's Nama (First, Middle, Last) George Watson Louise Wise 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis N. Watson/grandson 28011 White Pond Dr., Salisbury, MD 21801 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park 12/18/99 Salisbury, MD 21. Signature of Figneral Service Lie 22. Nama and Addrass of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Party Enter the disease, or before affock, or haert faitura. List only nplications thet caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrast, y one cause on each line. Approximata tritervat Between Onset and Death Immedieta Cause (Finet disaasa or condition rasulting in death) Sequentially tist conditions, if any, laading to immediate causa. Enter Underlying Dua to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f ahow

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Funeral

Completed

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permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryla Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "natural", or item 23a or 28a-1 ahov any Injury or other traumatic event, the Medical Examinal must be notified at

3altimore, Maryland 21215-0020

Physician/Medical Examiner Be Completed by Medicai Certification: To To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu

attending physicien end for use as the bunal-trans signed by t

The law requires that the death certificate be executed

or Attending Physician:

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Division of Vital Records, P.O. Box 68760,

that initiated events that initiated events rasulting in death) Last	d	to (or as a consequence of):				
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29c. License number

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State Registrar

29b. Signatura and titlerof certifier

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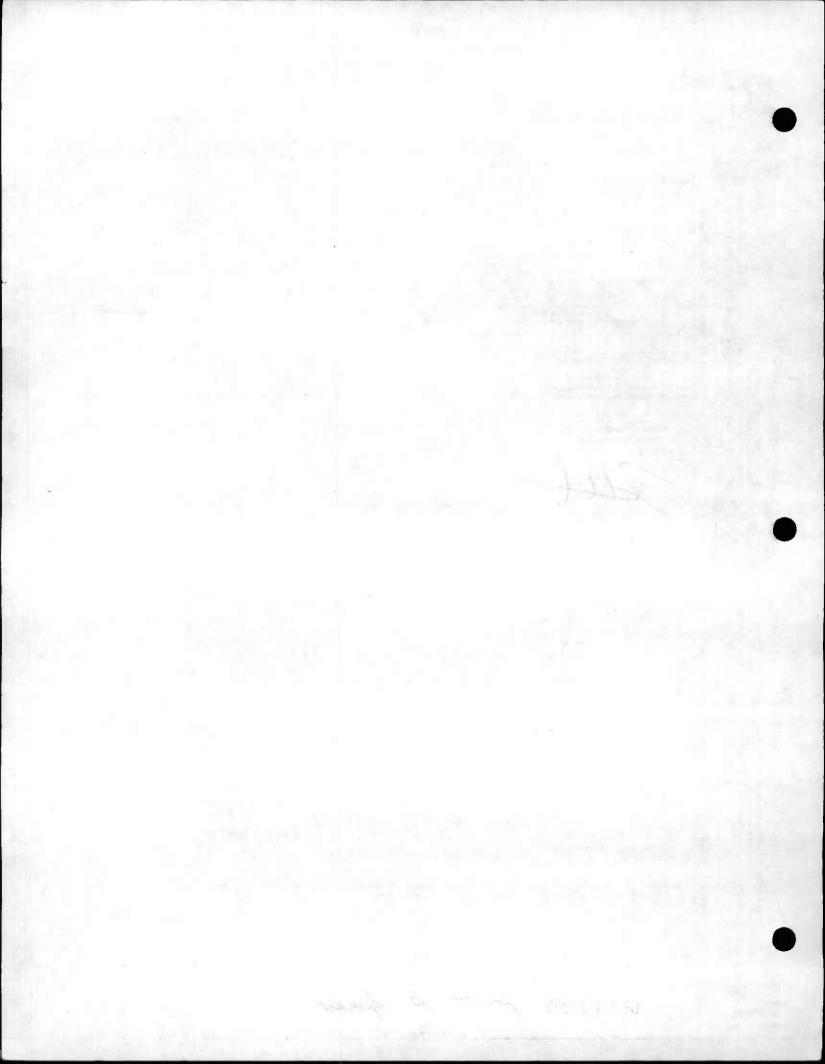
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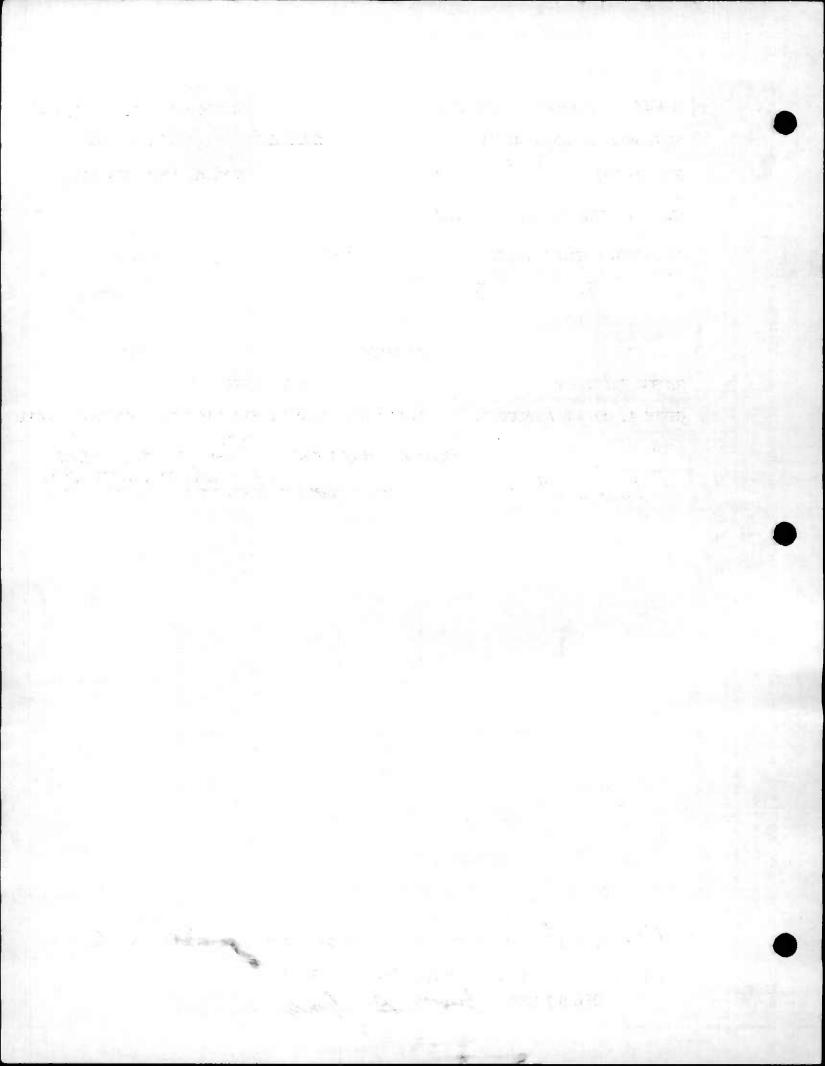
32. Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 40881

Physician Medical Examiner A. Feetily Name (first Abdidu, Late) TORMIE JUANITA WILLIAMS DECEMBER 6 1999 1: 05AM 45. City, Town, or Location of Death ANNE ARUNDEL S. Social Socially Number 6 5 are 1 10 at 20 ft 77 3 vs. Williams 1 10 at 20 ft 77 4 at 20 ft 7							Certificate	e of	Death		Reg. No.	SA.	10001
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth Month Z regler 999 05100 pm December 4b/City, Town, or Location of Death 4a Fepility Neme (If not institution, give street and flymber) 4c County of Deeth Baltomore un iversity ox 111dr If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 6. Sex 0 8. Dete of Birth (Month, Dey, Aug 23, 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 68 Yrs. Pennsylvania 213-30-0770 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 370 Dublin Drive 21060 USA 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. Biack, Whita, atc. 1 ☑ Yes 2 ☐ No 1952— If Yes, Give Yeer or Detes: 1954 1 ☐ Never Merried 2 ☐ Merried White 1 ☐ Yaa 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 1954 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4or 5+) Elementery/Secondery (0-12) Warehouseman Government 12 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fathar's Neme (First, Middla, Last) Karl H. Ziegler, Sr. Vera Elizabeth Pannypacker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mark Ziegler / son 11 Penny Lane, Pasadena, MD 21122 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Glen Burnie, MD Glen Haven Cemetery 1999 4 ☐ Donetion 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, eart failure. List only one cause on each line. Multiorgan System Immediate Cause (Finel diseese or condition resulting in deeth) InTUries PROPER BY MERICAL EXAMINES Part II. Other significant conditions contributing to death but not resulting in the underlying cause give in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

physician and the burial-transit

Physician/M

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Certification:

Box 68760.

Records, P.O.

Division of Vital

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ii Director: After this co

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: if them 27 is marked oths any Injury or other treumetic event

Physician

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MD

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Funeral

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dical Examiner must be notif

'naturel', or items 23s or

Saltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Wes en eutopsy performed?

24b. Were eutopsy findings available prior to completion of causa of deeth?

1 ☐ Yes 2 No

1 ☐ Yes 2 No

26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was casa referred to medical examiner?
1 1 Yes 2 □ No 27. Manner of Deeth 1 Neturet

5 Pending investigation

28a. Date of Injury (Month, Day Year) November 29,1999 1633 PM 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of Injury

Street

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred Otor Vehrele

crash 28f. Location (Street end Number or Rural Route Number, City or Town, State) F.L. Smallwood (Coad Anne Anendel Co, Md

29e. Certifier

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29b. Signature and titlerof certifier

29c. License number

29d. Data signed (Month, Dey, Year)

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

het MORFISCA 31. Dete filed (Month, Day, Year)

State Registrar

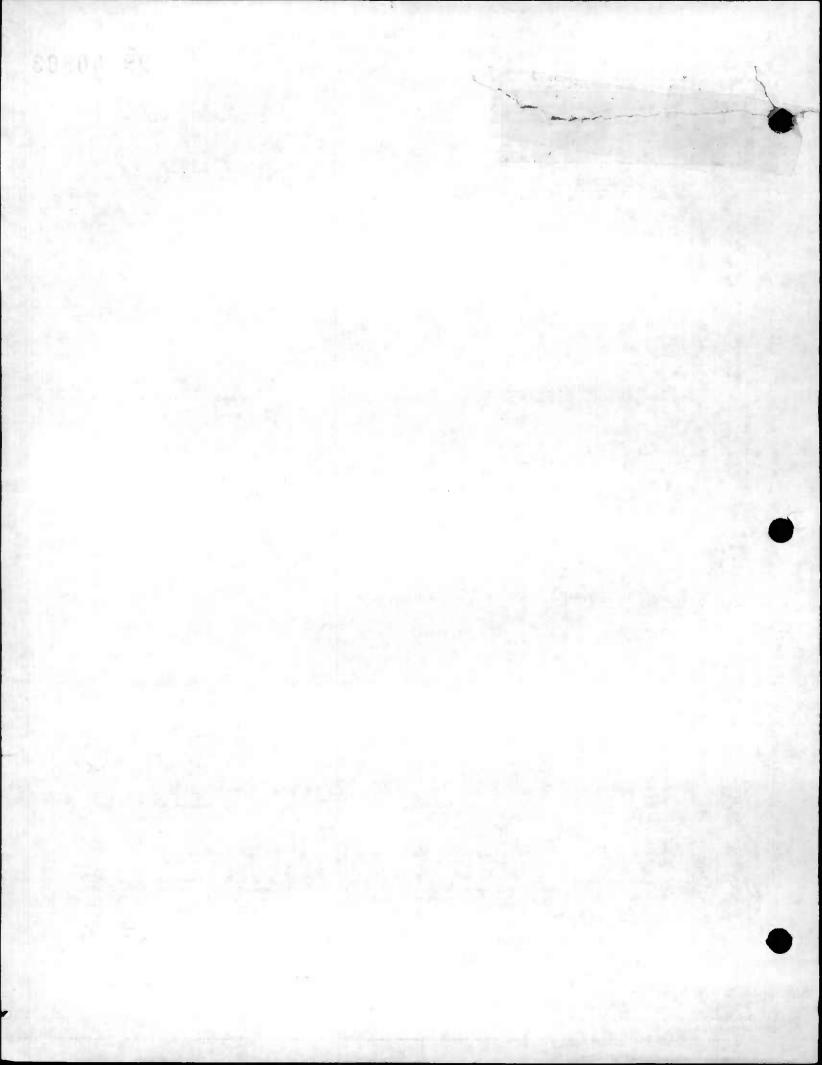


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B.K.S SANDRA A	DA.	MS EMS: #23 PART I	State of Ma	aryland	I/ Pep	artment	of H	lealth a	ind M	lental Hyg	iene 9	9	40883
Physicia	an	1. Decedent's Name (First, Middle, Last) SANDRA	-	- <u>! ME(</u>) 00,	imoute	011	30417		2. Date of Dea Month DEC		Year 99	3. Time of Death 0527 AM
Medic Examin		4a Facility Name (If not institution, give SINAI HOSPITAL	street and number) E.R.			if Under			TIMO	cation of Death	4c. County	of Death	
Funeral Director		Usual Residence of Decedent	х м 20 X K /. Ад	e (In yrs. la	Yrs.	Months	Deys	Hours	Min.	8. Date of Birth (Month, Day APR 27		MASS	plece (State or Foreign intry) ACHUSETTS
ith with the Marylar 23a or 28a-f show	Director	10a. State 10b. County MARYLAND N/A 10e. Street and Number			Town or Lo	ORE CI					On Citizen of \		10d. Inside City Limits 1 ⊠Xes 2 □ No
frems frems	by Funeral Dir	4604 PALL MALL RO	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:				2. ent of H ify Cube	1215 ispanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	0g. Citizen of Whet Country? U.S.A. 14. Raca - American Indian, Black, White, etc. Specify: BLACK		
2121 d within giene. or than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade	cation e <i>completed)</i> College (1-4or t	5+)	(Give	dent's Usuel kind of work DO NOT use OUSEWI	k done d e retired	du <i>ring m</i> ost f)			DOME	STIC	
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		Kenneth Johnson/ 20a. Method of Disposition 1 Buriel 2 ** Memation 3 BR 4 Donetion 5 Other (Specify)		Ce.	ace of Dispo metery, crea	Pelha psition (Name to ry or otto HILL C	e of her plac	ce)		Date	reenvil 20c. Location - BOSTON,	City or T	
Baltimo		21. Signature of Funeral Service Licensee 22. Name and Address of Fecility WILLIAM C BROWN 1206 W NORTH AVE						y N CO	MMUNITY				
Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complishock, or heart feilure. List only or Immediate Cause (Final disease or condition resulting in deeth)		ENSI	VE A	ND AT				TIC CA		ASCU	Approximete Interval Between Onset and Death LAR
876(dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b										
O. BOX 68' death certificat the attending phy hed for use as th	Physician/Med	Part II. Other significant conditions cor	d	ut not resul	ting in the u	nderlying ca	use giv	en in Part I.		23b. Dfd to	obacco use co	ntributa	to the cause of death?
S the set the bed	þ								-	1 □ Y			obably 4 Dunknown
Rec law las b	Completed									perfor	med?	8	ovailable prior to completion of cause of death?
Sicien: The certificate lirector, pag	Bec	25. Was case referred to medical examiner?							of Deat	h (Check only or	ne)		
at di	2	Z7. Manper of Death 1 Natural 5 Pending investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	iry :	ER/Outpatie 28b. Time o fnjury		Bc. fnjur Wor	4 LI NO		me 5 Resid 28d. Describe h			city)
DIVISION To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Inj building, et	ury - At hor c. (Specify)	ne, farm, st	reet, factory,	, offica			28f. Location (S City or Tow	treet and Numl n, State)	er or Ru	ral Route Number,
othe Hospital ithin 24 hours othe Funeral i	Medical	29a. Certifier (Check only one) 1 Certifying Physical American Examination 29b. Signeture entitle of certifier	ner: On the basis of and manner st	f examination	rledge, deet on and/or in	vestigation,	in my o	ne, date en pinion, dea e number	d pleca, th occurr	red et the time, o	euse(s) end malate and place, 29d. Date signe	and due	to the cause(s)
To with		30. Neme and address of person who co	propleted cause of o	death (Item	7 23a) (Type,	D		C.M.E			DEC. 2		
. Star		31. Date filed (Month, Dell, Year) DEC 3 0 199	32. Registr	rar's Signatu		Stre	et,	Balti	imor	e, Maryl	land 21	201	



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 3:45 pm DAVID BUTCHER DECEMber 23 1994 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) BonSecour Hospital Baltimore If Undar 1 Year | If Undar 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Data of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) Months Days 1□M 2□F Yrs. 212-36-1713 62 10 - 13 - 37MD Usual Residance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yas 2□No NΔ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1707 Westwood Avenue 21217 USA 12. Was Decedant Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 1 Yas 2 No Spacify: Specify: 3 ☐ Widowed 4 ☐ Divorcad Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Baltimore City 6th Grade 18. Mother's Name (First, Middle, Maidan Surmame) Sanitation 17. Fathar's Nama (First, Middle, Last) Handy Butcher Cleo Butcher 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 19a. Informant's Name/Relationship (Type, Print) Dora Lee Butcher 237 N. Dallas Court Baltimore, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ↓ Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Voshell Mem.Gardens 12-31-99 Dundalk, MD 21. Signature of Funeral Service Lic 22. Name and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter tha disaase, or conshock, or heart failure. List only Approximate Interval Between Onset and Daath EPTIC SHOCK x24hrs Immediata Causa (Final disease or condition rasulting in death) Due to (or as a consaquanca of): RENAL FAILURE STE WITH Electrolitics Arrythmia RC Due to (or as a consaquenca of): Imbalance. netabolic 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed?

Physician /Medical Examiner

and I-transit

attending physician affor use as the burial

signed by the a

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s certificate hes b

al or Attending Physician: T.s efter deeth.

I Director: After this certificat ed in by the funeral director, pg

n 24 hours efter dec Ne Funeral Director pletely filled in by the

Hospital

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

Examiner

Physician/Medical

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Physician

/Medical

Examiner

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Funeral

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MD

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Director

ed other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at

72 hours after

filed within Hygiene.

permit. Pages 1 and 2 should be filed.
Separation of Health and Merial Hydrogerant; if them 27 is many injury or other any injury or other.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 No 2PINO 1 ☐ Yes 25. Was case raferred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifier t Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and due to the causa(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signatura and title of certifier

within 2

31. Data filed (Month, Day, Year) State Registrar

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R.M. SHAM MD

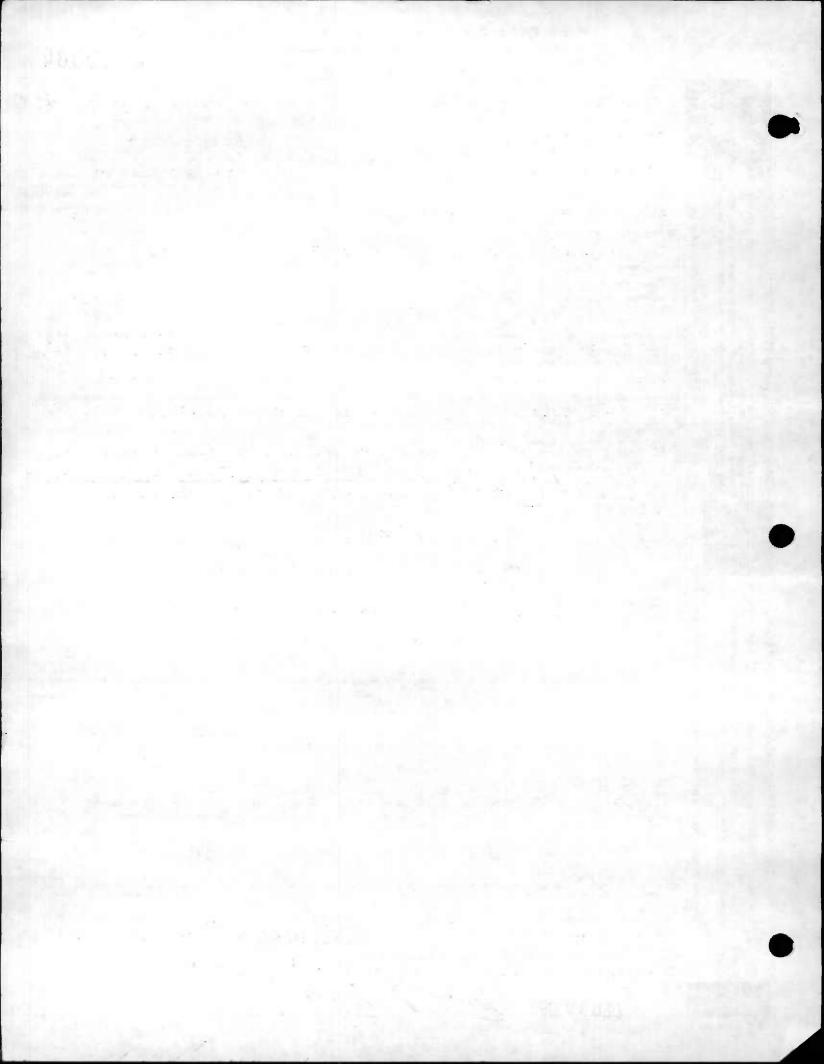
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Bon

32. Registrar's Signature

Seiner Hospital, Burmore mo

D0019668. December, 23, 1999



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 9 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death Month Day Yaar BROWN **Physician** MICHELE Declared 20 7:13PM 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat ST PAULPI. Examiner RCY MEDICALCENTER BALTIMORE BALTIMORE If Undar 1 Yaar | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1□M 2₽F 27 Director 07-26-72 MD 437-29-1929 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Director MD NA Baltimore 288-1 the Medical Examiner must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a or 2328 East Fairmount Avenue 21224 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ▼Never Married 2 Married natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 € No Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry De filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife 8th Grade in the home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be Department of Health and Mantal 1 important if them 27 is marked on any injury or other traumented on once. Be Melvin Watts 2 Alpha Brown 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 21224 19a. Informant's Name/Relationship (Type, Print) Alpha OV. Brown 2328 E. Fairmount Avenue Baltimore, MD

20b. Placa of Disposition (Nama of cametery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Voshell Mem. Gardens 12-27-99 Dundalk, MD of Funeral Service 22. Name and Address of Facility Baltimore, Maryland 21202 200 WM.C.March FH 1101 E. North Avenue Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner evere mont the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Last physician and s the buriel-tren Due to (or as a consequanca of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) attending | 98 been signed by the s should be deteched Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 SUnknown by 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yas 2 ☐ No 1 Yas 215 No certificate Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 WiNetural 5 Pending Investigation efter death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours e 29a. Certifier Tid Sertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es steted. To the Hosp within 24 ho To the Fune completely fi Medical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) moon 30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Registrar

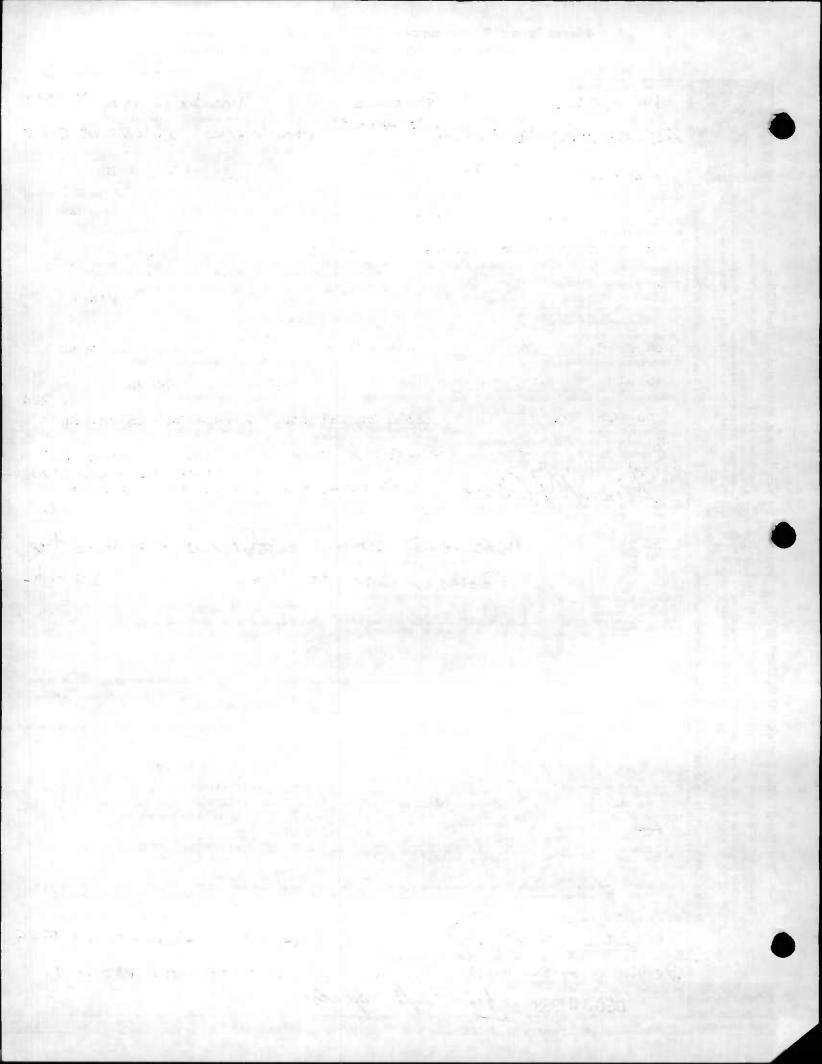
State

31. Date filed (Month, Day, Year)

DEC 3 0 1999

EN E- JOHNSON, M.D. 32. Registrar's Signatura

601 St. Paul Street Baltimore, Maryland



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death . Physician Month Delember BRUCE WILLIAM FRANCIS /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 214-20-7103 74 Director JUNE 4, 1925 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 STANHOME DRIVE 21061 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. Never Merried 2 Married Specify: WHITE If Yes, Give Year or Detes: 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) WAREHOUSE PERSONAL GROCERY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) and 2 should be a BRUCE MAKELL WITT.T. TAM SADIE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 STANHOME DRIVE, GLEN BURNIE, MARYLAND 21061 BETTY JANE STAPLER (NIECE) Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Pages 1 8 Buriel 2 Cremetion 3 Removel from Stete 12/31/ 4 ☐ Donetion 5 ☐ Other (Specify) CEDAR HILL CEMETERY 1999 BROOKLYN PARK, MD. 21. Signature of Funeral Service Lic 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Approximata Interval Between Onset end Deeth 23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock or heart failure. List only and cause on each line. **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner PNEHMONIA use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest The law requires that the death certificate be axec Box 68760. Due to (or as a consequence of) signed by the all the detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3☑ Probably 4 Unknown Division of Vital Records. p 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Be Completed 20 No 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician; 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 12 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menper of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Naturel 5 Panding after death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital within 24 hours To the Funer completely file 29a. Certifier 🎾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) end manner steted. (Check only one) \$ 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 1140

DHMH 16 Rev 6/95

State Registrar

NI FR

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

30) HU34 32. Registrar's Sign

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Joseph Brown 12 26 1999 1:10 am 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Daath **BROADMEAD** COCKEYSVILLE BALTIMORE If Undar 24 Hrs. Hours Min. 5. Social Security Number If Undar 1 Yaar 8. Data of Birth (Month, Day, 1/8/22 7. Age (In yrs. lest birthday) 9. Birthplece (Stata or Foraign Days Months 1₽M 2□ F MARYLAND Yrs. 216-01-9640 87 Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No BALTIMORE COCKEYSVILLE 10e. Street end Number 10f Zip Coda 10g. Citizan of What Country? 13801 YORK ROAD APT. F-12 21030 USA 12. Was Decedant Evar In U,S. Armed Forcas? Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) Collega (1-4or 5+) 4 YEARS ELECTRIC ENGINEER WESTERN ELECTRIC 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) ALBERT E. BROWN, SR. CATHERINE M. EIKENBERG 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) ALBERT E. BROWN, JR. BROTHER 858 SOUTHEAST 41st ST. CAPE CORAL, FL 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20e. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donatigh 5 ☐ Othar (Specify) METRO CREMATORY, INC. 12/27/99 CATONSVILLE, MD 21. Signatura of Funeral Service Licens 22. Name and Addrass of Facility

Physician /Medical Examiner

> use as the bunei-transi attanding physician and

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certificata

rector: Af à ā

within 24 hours To the Funeral

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital neuri or Attending Physician: **Physician**

/Medical

Examiner

10a. Stata

MD

Director

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Completed

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Physician/Medical

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Medical Certification:

Funeral

Director

the Maryland

pamit. Pagas 1 end 2 should be filed within 72 hours aftar death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Med cal Examinan must be notified as

Baltimore, Maryland 21215-0020

29b. Signature and titla of contilion

31. Data filad (Month, Day, Yaar)

30. Name and eddress of person who complated cause of death (Item 23d) (Type, Print)

DEC 3 0 1999

32. Registrer's Signatura

Immadiata Causa (Finel disaasa or condition resulting in daath)

8521 LOCH RAVEN BLVD. 21286 23a. Part 1. Enter the disaasa, or complications that caused the daath. Do not enter shock, or haart failure. List only ona ceusa on aach line. Approximata Intarval Between Onsat end Daath the mode of dying, such as cardiac or respiratory arrest, Due to (or es a consequence of):

29d. Data signed (Month, Day, Year)

THE JOHNSON FUNERAL HOME, P.A.

Sequantially list conditions, if eny, laading to immediata causa. Enter Undartying Cousa (Disaasa or injury	Dwe to (or as a consaquance of):		J corwij	man	
thet initiated evants rasulting in death) Last	Dua to (d	or as a consequence of):				
Part II. Other algnificant conditions multi-inf	contributing to death but not rec	sulting in the undarlying cau	se givan In Part I.	23b. Did tobacco uee con 1 ☐ Yes 2 ☑ No	atributa to the cauaa of death?	
Atrial	Gibrill.	stron		24a. Was an autopsy performed?	24b. Wara autopsy findings evailable prior to completion of cause of death? 1 \(\text{Yas} \) 2 \(\text{No} \) No	
25. Was case rafarrad to medical			26. Placa of Da	rath (Chack only one)		
axaminar? 1 Yes 2 No	Hospital: 1 ☐ Inpatiant 2 ☐	ER/Outpetient 3□ DOA	Home 5 ☐ Residence 6 ☐ Othar (Specify)			
27. Manne of Deeth 1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant invastigati		28b. Tima of Injury M	injuryet Work? 1 ☐ Yas 2 ☐ No	28d. Dascriba how injury occur	ed	
3 ☐ Suicida 6 ☐ Could not datarmina		oma, farm, streat, factory, o	281, Location (Straat and Numbar or Rural Routa Number, City or Town, Stata)			
29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my known in the basis of axamina and mannar stated.	owladge, death occurred et ation end/or investigetion, in	tha tima, data and plac my opinion, death occ	e, and due to the ceuse(s) end ma urred et the time, dete end plece,	nnar es statad. end due to the ceuse(s)	

State Registrar

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneg 40888 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Bryant 9:30 A.M. **Physician** 12 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (II not institution, give street and number) 4c. County of Deeth Examiner 2506 Baltimore redende Avenue If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9-23-1926 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) / / // **Funeral** 10 M 20 F Months Deys 214-20-387 Yrs. Director Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits Baltimore 1 Yes 2 No Director 28a-f 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Numbe Avenue redenck 21223 U.S.A 238 2605 Funeral Herra 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglane. Important: If Item 27 is marked other than 'natural', or ite any injury or other traumatic event, the Model Estimate in injury or other traumatic event, the Model Estimate. 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Barrell Elementery/Secondary (0-12) College (1-4or 5+) Company 9th grade NA Baitimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Bryan Cunice POIK 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bryant Iretta Avenue Baltimore, Hd 21223 Frederick 2506 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) -3-2000 21. Signeture of Funeral Service Licenses 23. Name end Address of Fecility 2/2/5 F, H D land Wabash Warne Guenue Salto, red 0 0 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Proumonta Aspiration 2 weeks Examiner Due to (or as e consequence ot): Physician/Medical Examiner CVA End Stage Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760. Due to (or es e consequence of): signed by the attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records. Completed by 24b. Were eutopsy tindings evailable prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending investigation 1 Preturel death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the within 24 hours after deat To the Funeral Diractor: 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a, Cartifier (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year)

State

State Registrar

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31. Dete filed (Month, Day, Year) DEC 3 0 1999

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30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

m.D.

32. Registrar's Signeture

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Rd #204 Catourville

Dec., 28

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneg 40889 AMENDED ITEMS 24a,25,26,27,29a PER MD G778 12/30/99 AH Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** William Bishop 6, Dec. 1999 12:01PM /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City. Town, or Location of Daeth 4c. County of Death **Examiner** Memorial Hospital @ Easton Easton, MD Talbot | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Month Days | Hours | Min. | Aug o, 7. Aga (In yrs. last birthdey) Birthplaca (Stata or Foreign Country) 5. Social Security Number **Funeral** 1X0 M 2□ F 70 Yrs. 216-28-9428 Director Usual Rasidance of Decedant the Maryland 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits show other traumatic event, the Madical Examiner must be notified at MD 1 ☐ Yas 2 ☐ No Director Queen Anne Centreville or 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? with Bishop, William Byron or itema 23a 205 Armstrong Ave 21661 USA Funeral deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1 Nevar Married 2 ☐ Married White 1 ☐ Yas 2 ☐ No Specify: Specify: à 3 Widowed 4 Divorced "natural", Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) end 2 should be filed within eath and Mental Hygiene. n 27 is marked other than Elamantary/Secondary (0-12) Collage (1-4or 5+) 12 0 drywall installer construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Byron Gurney Bishop Sarah Ella Mitchell permit. Pages 1 end 2 sh Depertment of Health and Important: If item 27 is m any injury or other traum once. 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Dorothy Seeds/sister 17 Prospect Bay Dr West Grasonville, MD 21638 20b. Place of Disposition (Nama of cemetery, crametory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramovel from Stete
4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Fineral Service Lioensees. Wade, Director 22. Name and Address of Facility Board 655 W. Baltimore Street 21201 Baltimore, MD urt 1. Entar the disaasa, or complications that caused tha daeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, lock, or haart failura. List only ona causa on aach lina. Approximata intarvai Betwaan Onset and Death Physician immediata Causa (Final disaase or condition resulting in daath) /Medical Sepsis Examiner Due to (or as e consequance of): Preum Mia ed by the attending physician and detached for use as the burial-transit Exami Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury Due to (or es e consequance of): of Vital Records, P.O. Box 68760, certificate be Physician/Medical that initiated evants rasulting in daeth) Last Due to (or es e consequança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ should ! 24b. Wara autopsy findings avelleble prior to Completed 24a. Was an autopsy performed? complation of causa of death? page 2 ete 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No this centilic Be 25. Wes casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 ☐ Yes 2 ◯ (No 1XXinpatlant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Describe how Injury occurred Certification: 1 Watural 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Sulcide Location (Street and Number or Rural Roufa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify) 4 Homicida edicai 29a. Cartifiar 1 💆 Certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. To the Hos within 24 hr To the Fun 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stetad. 29b. Signatura and titla_of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) Orman 12/4/99 M400 455274

State Registrar

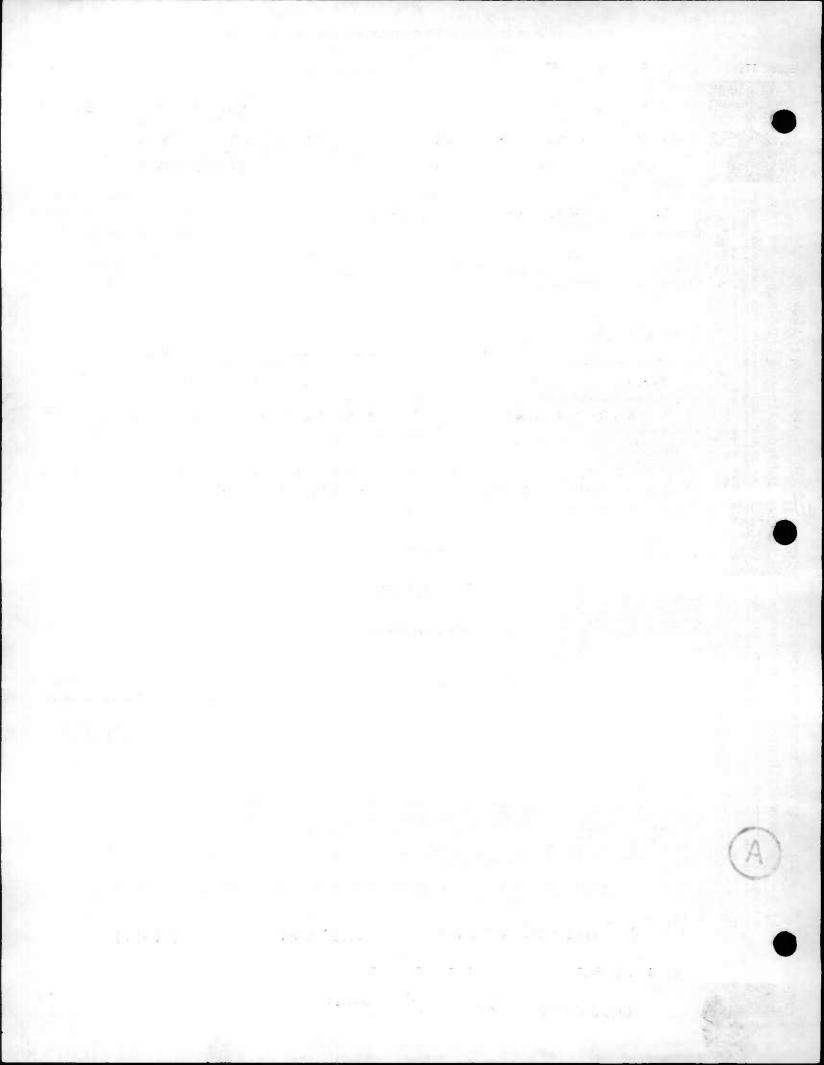
JEANINNE EJNFALTDO 31. Data filed (Month, Day, Year)

DEC 3 0 1999

32. Registrer's Signetura

30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print)

219 S WASHINGTON ST., EASTON. MD south



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Jr. 28, 4:30 AM Dec. 1999 Thomas Edward Booth /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 2801 McComas Ave. Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country)
7 Maryland 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Days 10XM 2□ F Yrs. Director 220-62-1594 June 29, Usuat Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Maryland Baltimore 1 ☐ Yes 2 No Director Dundalk 10e. Street and Number 10g. Citizen of What Country? 238 2801 McComas Ave. 21222 Funeral natural', or items 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status a filed within 72 hours after d if Hygiene. other than "natural", or Item Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Telecommunications Tech | Communications permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked offin any Injury or other treumstic event obtas. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Edward Booth Sr. Sue N. Lockamy 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue N. Booth - mother 2801 McComas Ave. Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 12/29/99 Towson, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, to the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, that only one cause on each line. Approximate Intervat Between Onset and Deeth 23a. Part1. Enter the sea shock, or heart search **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manper of Deeth 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Naturel n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fur 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 30641 SO wel

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State Registrar N.

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32. Registrar's Signeture

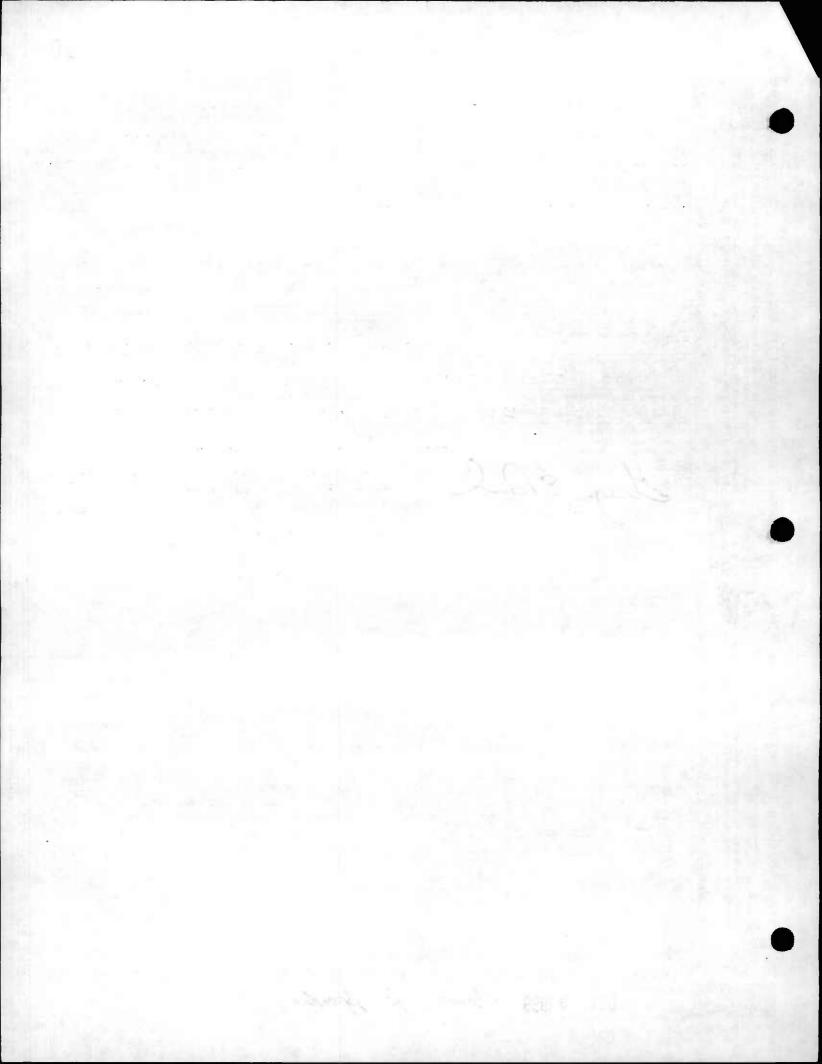
Eutaw St #308 Balto. Md. 21201

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Sabapathi

Kamesh

31. Date fited (Month, Day, Year)
DEC 2 9



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q FU831 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** John Theophiles Carter December 23, 1999 2:40p.m. /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Levindale Hebrew Geriatric Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** M 2DF Months Days Hours 229-18-4317 78 Yrs. Director March 11, 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location. 10d. Inside City Limits Md. n/a 1 Yas 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 3908 Chatham Road 21207 USA 'natural', or items Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Merital Status 14. Race - American Indian, Black, Whita, atc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ You Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Army Publication mentary/Secondary (0-12) College (1-4or 5+) US Govt. permit. Pages 1 and 2 should be flied a Department of Health and Mental Hygies importants if Item 27 is marked other than any injury or other treatments event, the 2056. 12th Grade Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Levi Carter Ophelia Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel C. Carter wife 3908 Chatham Road Baltimore, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Removal from State
4 Donation 5 Other (Specify) Garrison Forrest Veterans Dec. 29 Owings Mills, Md 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Nutter 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical NEUMONIA Examiner Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 20 No 1 Yes 20 No certificate Be 25. Wes case referred to medical 26. Placa of Death (Check only one) Hospitel: Inpatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 10 1 Yas 2 No 2 ER/Outpatient 3 DOA #14 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Attar Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

P.O. of Vital Records. The law Division Attending al or Attending after death. à To the Hospital within 24 hours a Louis Funeral Completely filled

nd 21215-0020

Saltimore,

6 Could not be determined

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

UC Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and manner steted.

29b. Signature and titla of certifier alneu

4 THomicide

29a Certifier

Halellan

29c. License number

HEIGHTS

29d. Data signed (Month, Day, Year) 99 25

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) FASNERM CAKHAMI, 7220 PARK

31. Date filed (Month, Day, Year) DEC 3 0 1999 32 Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

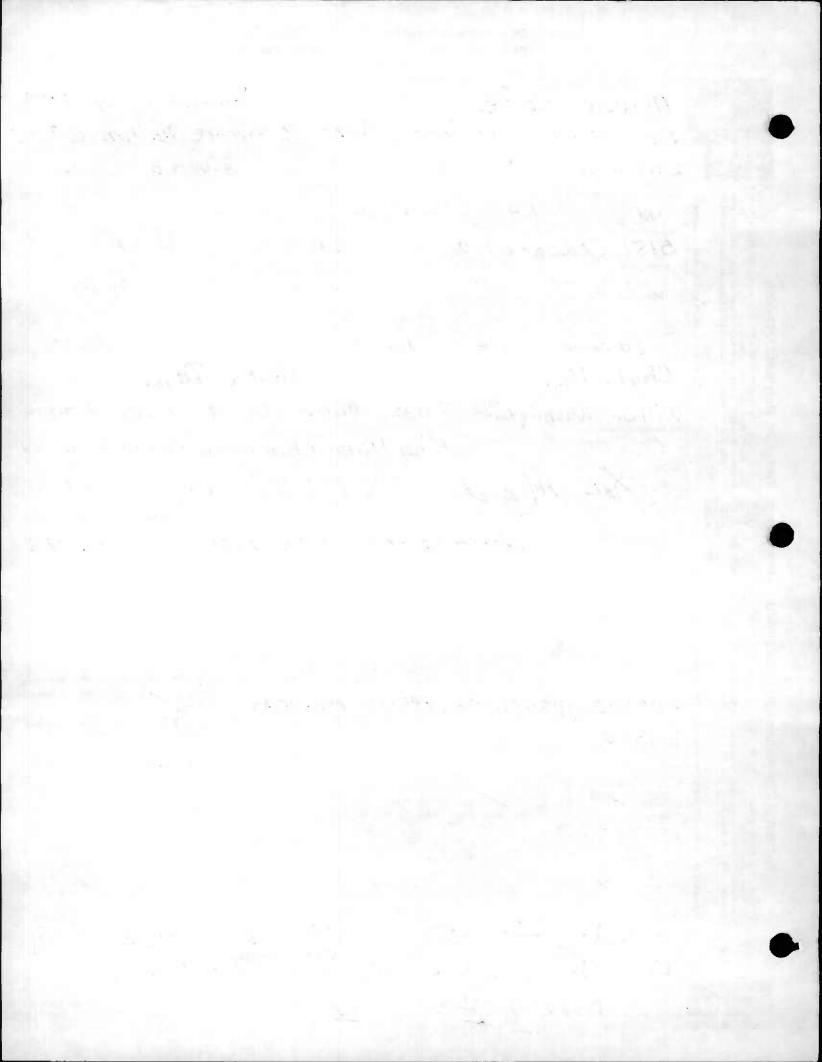
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Physician /Medical	Catherine Fra	nces C	oogan				Dec.			3:05 PM		
Examiner	4e Facility Name (If not institution, gi		ımber)			4b. City, Town, or Lo		,				
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how how	10a. Stete 10b. County		10c. Ci	ly, Town or Lo	ocation				100	d. Inside City Limits		
o Ma Safe filled	MD Harfor	d		Bel Ai	r					1 Yes 2 No		
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1215-0020 within 72 hours after are. than "natural", or its the Medical Examina mpleted by Fu		If Yes, G	ive		1 Yes 2 No	Specify:		Specify:	Wh	ite		
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should no Market market umeric							al Route Numb	ber, City or Town,	State, Zip C	Code)		
	John F. Coogan,	Jr./Sc	on	1201	Bancrof	t Ct., Be	I Air,	MD 2101	4			
P - I see	20a. Method of Disposition	70		Place of Disponentery, cre	osition (Nama of metory or other ple	ce)	Data	20c. Location -	City or Tow	n, Stata		
altimor nii. Pages artment ol i ortant: If liu injury or o	1 Mauriel 2 ☐ Cremetion 3 I			oreland	d Memoria	al Park	12/31/9	9_Baltime	ore.	MD		
Baltimore, permit. Pages 1 av Department of Hea important; If Isem; any injury or other ance.	2 Signature of Funeral Service City	PT) _ (2	2:	2. Neme end Addre							
M 20288	Michael J.	Flagle				donia Rd.		nium, Mi	D 210	93		
	23e. Pert1. Entar tha disaasa, or cor shock, or heert failure. List only	nplications that	causad tha daa eech line.	th. Do not en	ter the mode of dyi	ng, such es cardiac	or respiretory	arrest,	. 1	Approximete Interval Between		
Physician /Medical	Immediate Cause (Fine)									Onset and Death		
Examiner	Immediate Cause (Final disaese or condition resulting in deeth)	a. DE	MENTIA								-	
<u> </u>			Due to (or es e conse	quence of):				1			
8760, sate be executed shystcian and the burial-transit dical Examiner	Sequentially list conditions	b	Due to (or es e conse	quenca of):						_	
. Box 68760, death certificate be executed e attending physician and nd for use as the buriat-transit sician/Medical Examir	Sequentially list conditions, I li eny, leeding to immediate cause. Enter Underlying											
68760, ificate be expression as the burial edical E	Causa (Disease or injury c. that initiated events resulting in death) Last Due to (or es e consequence of):											
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Box auth cert for use			MALE STATE	1 C 13					1			
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The law ate hes the page 2 s							10	Yes 217 No		Yes 2□ No		
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Of Vital Physician: T this certificat ral director, p	axaminar? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Ott	her: 4 Nursing Ho	ome 5 Res	sidence 6 K Othe	er (Specify)	HOSPICE		
ding Pt. After th funeral	27. Manner of Death 1 X Naturel 5 ☐ Pending	28a. Dete (Mor	of Injury oth, Dey Year)	28b. Time of Injury	of 28c. Inju	ry at rk?	28d. Describe	how injury occurr	red			
Vision Attending or death. ector: After by the fune	2 Accident Investigetic 3 Suicida 6 Could not	he				Yes 2□No	001 1 6	(O	D1	Don't Hank and		
Division of the or Attending Prisate death. al Director: After the or in by the funera Certification:	4 Homicide determined	286. PIGC	a of Injury - At h ling, etc. (Speci	ome, ferm, st fy)	reet, factory, office		City or To	(Street and Numb own, Stete)	er or Hunai	Houte Number,		
ours ours filled filled	29e. Certifier 1♥ Certifying P	hysician: To the	a hest of my kno	wiedne deal	th occurred at the ti	me, date end place,	and due to the	a cause(s) and me	nner as sta	ted.	-	
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. Do the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		minar: On the b				opinion, death occur						
Within comp	29b. Signeture end title of certifier				29c. Licens			29d. Date signed		ay, Year)		
	101=				Dy	3725		12/3	0199			
111	30. Neme end address of person who					ТИОНТІВ	I MD 0	1002				
State	DR. TARIQ MAHM 31. Date filed (Month, Day, Year) DEC 3 0 1999		Registrar's Sjor		LLEY RD.	TIMONIUM	, MD Z	1033			-	
Registrar	DEC 9 0 1333		/	.,								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40893 Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month **Physician** AM December laude 29 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Hopkins Gerjathic mor If Undar 24 Hrs. 8. Data of Birth (Month, Day, If Undar 1 Yaar 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Months Days 1□ M 200 F Yrs. 217-54-2360 Director Usual Rasidanca of Dacedant the Maryland 10a. Stata 10c. City, Town or Location 10d, Inside City Llmlts 10b. County 28a-1 show traumatic event, the Medical Examiner must be notified at Baltimore 1 Yas 2 No NA Director Md 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 8 edgate Ra 21206 U.S.A 515 238 Funeral death 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. or items 11. Marital Status parmit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 Yas 2 No 1 Navar Marriad 2 Married specity: Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ◯ No Spacify þ 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) J. H.H Elamantary/Secondary (0-12) Collaga (1-4or 5+) Bayven assistance NA 8th grade 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) Be aune 19a. Informant's Name/Ralationship (Typa, Print) Grandson 19b. Mailing Address (Street and Numbar or Rural Route Number, City of Town, Stata, Zip Coda) Cedarcroft Ra Balto, Md 21239 1321 William Washington 20b. Place of Disposition (Nama of conetary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition b 1 Burial 2 □ Cramation 3 □ Removal from State Randallstown, Md -4-2000 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Fungral Service Licensee 22. Name and Addrass of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. grenue Approximata Interval Batwaen Onset and Death **Physician** Immadiate Cause (Final disease or condition rasulting in death) /Medical . metastatic cervical carcinoma Examiner Dua to (or as a consequence of) Examiner law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last the buriel-trar Dua to (or as a consaquance of) Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) USB as ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by t 1 Yas 2 No 3 Probably 4 Unknown glaucoma ves/cocutameous by 24b. Ware autopsy findings available prior to completion of causa Completed 24a. Was an autopsy parformed' 1 Tas 2FING 1 ☐ Yes 2 ☐ No Division of Vital funeral director, Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No al or Attanding Physics effer death.

I Director: After this c 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how Injury occurred 5 Panding invastigation Natural 1 Yas 2 No 2 Accident Could not be datarmined 3 Suicida Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida Hospital 6 24 hours e Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical 29a. Cartifier (Check only one) within 2 To the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifiar 383 who complated cause of death (Item 23a) (Type, Print) 105 Hopau Cc 30. Name and address of pu 20 2 31. Data filed (Month, Day, Yaar) 32. Radistrar's Signatura State 1 Och Kez Registrar DEC 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day RALPH COCHRAN December 27, 1999 12:50 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Baltimore Baltimore Robabilitation and Extended Care N/A If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 7. Age (In yrs. lest birthday). 78 Yrs. 8. Date of Birth (Month, Dey, Yeer) 4-27-21 5. Social Security Number Birthpiece (Stefe or Foreign Country) 219-01-6903 100 M 2□ F NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1828 Wilhelm Ave. 21237 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ሺ Yes 2 □ No WW II If Yes, Give Yeer or Detes: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Driver Motor Freight 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Mack Andrew Cochran Anna V. Reed 19a. fnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Viola M. Cochran/wife 1828 Wilhelm Ave. Rosedale, MD 21237 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Holly Hill Cemetery 12-30-99 Middle River, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licans 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23e. Pert1. Enter the disease, or complications that caused the month of the month of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line Multi-infarction Dementia Immediate Ceuse (Finel disease or condition resulting In death) Due to (or es e consequença of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuee of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 219 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred

Division of Vital Records, P.O. Box 68760,

Examiner or Attending Physician: The law requires that the death certificate be executed buriel-trar been signed t this After t To the Hospital or Attending within 24 hours efter deeth.

To the Funeral Director: Afte completely filled in by the fun

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

or items 23a or 28a-f show

permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If them 27 is marked other than "netural", or iter any injury or other traumatic event, the Mexical Exaumone. Once.

Physician

/Medical

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Saltimore, Maryland 21215-0020

death

Director

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Completed

Be

State Registrar

31. Date filed (Month, Dey, Yeer)

DEC 3 0

1 Naturel

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

29b. Signature end title of certifier

5 Pending investigation

6 Could not be determined

28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner steted.

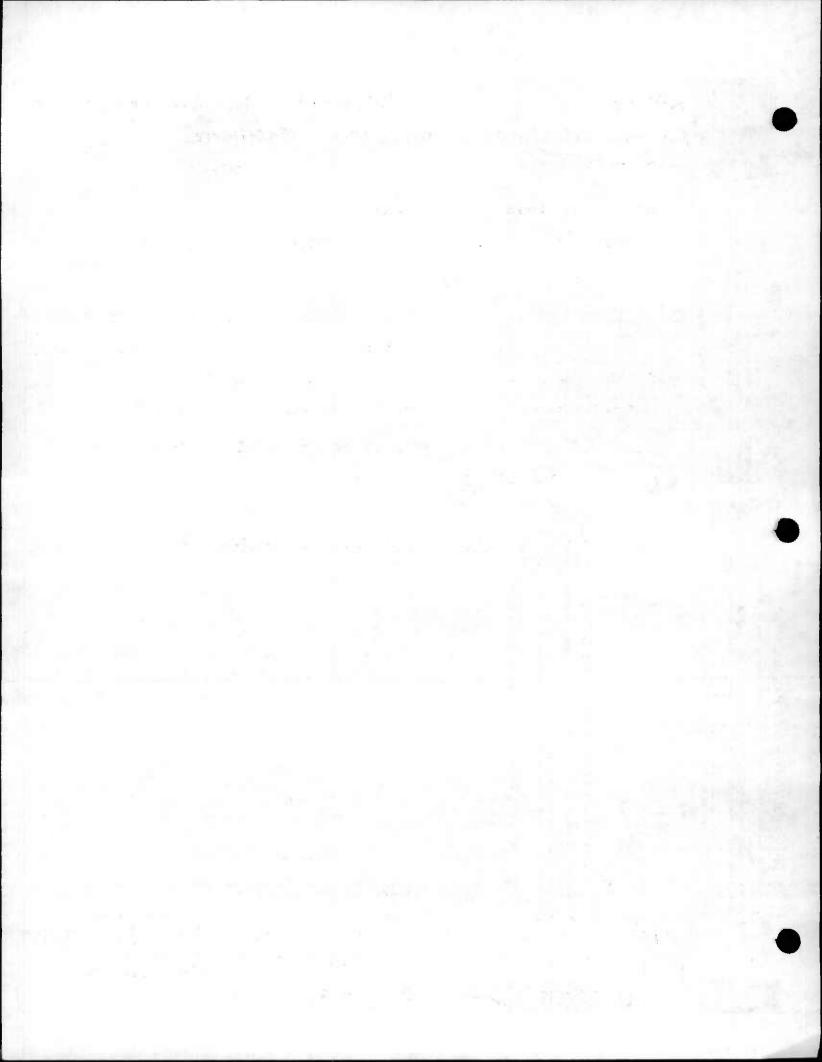
1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year) December 27,1999

28f. Location (Streef and Number or Rurel Route Number, City or Town, Stete)

My My My D0032548 December:
30 Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) (2 North Evrene Street
Baltimore, MARYLAND)

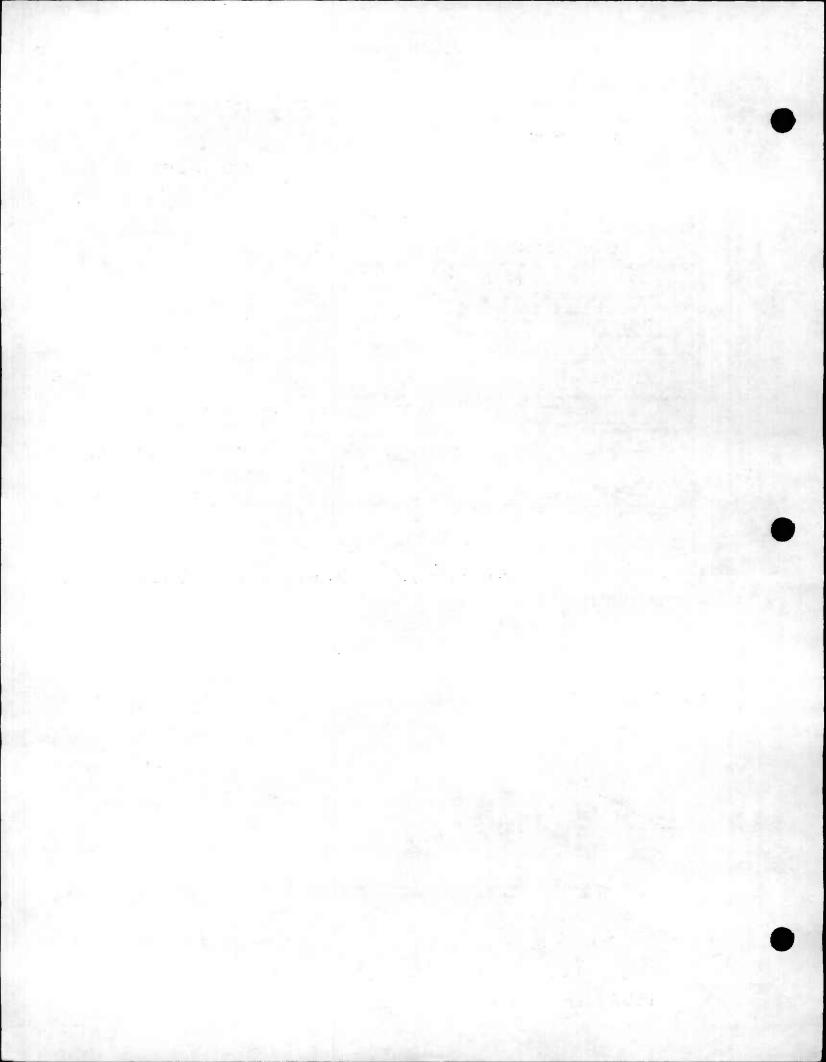
32. Redistrer's Signeture



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State of Maryland / Department of Health and Mental Hygiene 99 40895

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Physician /Medical	LE	ONARD			OHEN	DECEMBE		
Examiner	4a Facility Nama (If not institution, gi	iva street and number)		4	lb. City, Town	, or Location of Death	4c. County of D	
	CHERRYWOOD NURS	ING HOME		R	EISTER	STOWN		BALTIMORE
Funeral Director		Sex 1 IZM 2 □ F	rs. last birthday) 76 Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Data of Birth (Month, Day, JULY 7,		Birthplace (Stata or Foraign Country) MD
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vith the Ma or 28a-fe be notified Director	10e. Street and Number	A		10f. Zip Code		1	0g. Citizen of What	Country?
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020 uns after al., or the burnical	11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1X Yas 2 No	VII	Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 1 No	lispanic Origin an, Mexican, F Specify:	? (Specify Yas or No- Puarto Rican, etc.)		marican Indian, /hita, atc. WHITE
2 ho	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	d condition	16b. Kind of Busine	ss/Industry
I 21215-0 led within 72 ho lygiene. The Header Institute of the Completed	(Specify only highast gr Elemantary/Secondary (0-12)	College (1-4or 5+)	tifa.	DO NOT use retired	during most of	WORKING		
	10		PAINT	CER			CONTRACTO	R
Be ever	17. Fathar's Nama (First, Middla, Las.	0				Nama (First, Middle, M	Maiden Sumama)	
arylan should be and Mentel marked o	MICHAEL			HEN	SARA			BRENNER
Maryland d2 should be file th and Mentel Hy 71s marked oths traumatic event	19a. Informant's Name/Relationship HARRISON M. COF					REISTERST		
Nore, Maryle	20a. Mathod of Disposition		. Place of Dispo	osition (Nama of			20c. Location - City	
Baltimore, pemir. Peges 1 er Department of Hea Important: If Nem 3 any Injury or other once.	1 ⊠ Burial 2 □ Cramation 3 [4 □ Donation 5 □ Other (Speci			matory or other place ANS CEMET		12/29/99	OWINGS	MILLS, MD
Ball permit Depart Import any In	21. Signatura of Funeral Service Lice	nsee		2. Nama and Addre		SOL LEVINS		•
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Physician	snock, or neart failura. List only							Intarval Between Onset and Death
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On of ding Phys. h. After this funeral d	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe ho	ow injury occurred	
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Hospi 4 hou Funer taly fill	29a. Certifiar (Check only one) 2 Medical Exam	nysician: To the best of my ki miner: On the besis of exami and mannar stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and p pinion, death	place, and due to the coccurred at the time, d	ause(s) and manne ate and place, and	or as stated. dua to the causa(s)
within 2 To the comple	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Data signed (M	ionth, Day, Year)
	Mayor A.	2000	_	D1	5878	2 D	cember	28 1999
11	30. Nama and addrass of person who	completed causa of death (it	em 23a) (Type.	Print) 1				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#5-22 PER K.B. G778 12-29-99 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Daath 2. Date of Death Day Year **Physician** RAYMOND RAINBOW COLE 16 1999 23:53 Aug. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System Baltimore Hours Min. 8. Date of Birth (Month, Day, Year)
AUG. 10, 1999 If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country)
 MD . 7. Age (In yrs. lest birthdey) **Funeral** Days 10 M 20 F Yrs. Director 6 NONE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at BALTIMORE 1 XYes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or U.S.A 21217 2329 DRUID HILL AVE. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ੴNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11. Marital Status e filed within 72 hours after al Hygiene. 17 Never Married 2 Married Baitimore, Maryland 21215-0020 BLACK 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any Injury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be DIONNE COLE RAYMOND ADAMS SR. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2329 DRUID HILL AVE. , BALTIMORE, MD. 21217 DIONNE COLE/MOTHER 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee STATE ANATOMY BOARD, 655 W. BALTIMIRE STREET RONALD S. WADE DIRECTOR BALTIMORE, MD. 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Pulmonary Hypertension 20 hrs. Examiner Cardiomyopathy Physician/Medical Examiner 158 hrs physician and s the burial-transit law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hydropo Fetalis 158 hrs. P.O. Box 68760. Due to (or as a consequence of) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Prematurity Renal Insuffiency Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy certificate 1 ☐ Yes 20 No 1 ☐ Yes 2 No director 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: 1 Ninpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accidant 5 Pending

Division of Vital Attending Physician: Affer

Certification: To edicai

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune.

(Check only one)

3 Suicide

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 11SBAH. A. (LURESH)

investigation 6 Could not be determined

29c. License number

D0051310

1 Yes 2 No

29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

118BAH. A · EXURESHI 22 South Greene St. Baltimore, MD 21201 31. Data filed (Month, Day, Year)

Registrar

DHMH 16 Rev 6/95



28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

e. e. 1 = 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q

		END#19a&B PER HOSP. G778 12-29-99 J.A. Certificate of D 1. Decedent's Name (First, Middle, Last)							Reg. No. 2. Dete of Deeth Month Dey Yeer 3. Time of Deeth				
Physici /Medio		William Cook							-	ber 15.	1999 22	2:45	
Examir		4e Fecility Neme (If not institut		4b. City, Town, or									
		Greater Balti	lmore	Medical	Cent	er		Towson	Baltimore				
Funeral Director		5. Social Security Number	6. Sex	M 2□ F	ge (In yrs. I		If Under 1 Year Months Deys	If Under 24 Hrs		h y, Yeer)		Stete or Foreign	
		Usuei Residence of Decedent										ıq	
Men Man		10e. Stete 10b. Coun	ity		10c. City	, Town or Loca	tion		100		10d. Ins	ide City Limits	
Mar Mar	to	MD Balti	more		Ra	1timore					10	Yes 2 XNo	
the not	Director	10e. Street end Number	IMO L C		1 100	TUTIOTO	10f. Zip Code			10g. Citizen of V	Vhet Country?		
With with	0	4722 Willston Street 21229								USA			
Pe 2;	era	11. Marital Status	_	2. Was Decedent	Ever In U.	S. 13. Wa		Hispenic Orlgin? (S	pecify Yes or No		e - American Ind	ien.	
be filed within 72 hours efter death with the Maryland ital Hygiene. d other than "natural", or flems 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Mills	arried	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes:	2		es, specify Cub Yes 2⊠ No	Hispenic Origin? (Sean, Mexicen, Puerl Specify:	o Rican, etc.)	Specify Specify	k, White, etc.		
d within 72 hours ef giene. or than "natural", or	8		ent's Educ				nt's Heuel Occur	netion		16b. Kind of Business/Industry			
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- c4 in		19e. Informent's Name/Reletio						t end Number or Ri			Stete, Zip Code)		
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permit. Peg Depertment Important: I any Injury conce.		21. Signature of Funeral Service			- Ha		Neme end Addre		10/15/52	Daltim	, m		
Depermine on the concession of		GBMC - 6701 N Charles St., Baltimore, MD 21204 23e. Pert1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximate Intervel Between Onset end Death Onset and Death											
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		23e. Pert1. Enter the disease, shock, or heert feilure. Li	or complication on the contract of the contrac	ations that ceuse cause on eech	d the death ine.	. Do not enter	the mode of dyl	ng, such as cerdia	c or respiretory a	rest,	Appro	ei Between	
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/Medical		Immediate Cause (Final disease or condition		Prematu	re ru	pture o	f membr	anes			un	known	
Examiner		disease or condition resulting in deeth) Premature rupture of membranes unknown when the consequence of the											
	edical Examiner			Prematu				tation			20	min.	
The law requires that the death certificate be executed the hes been signed by the ettending physician and page 2 should be deteched for use as the bunel-transit		b											
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F. James

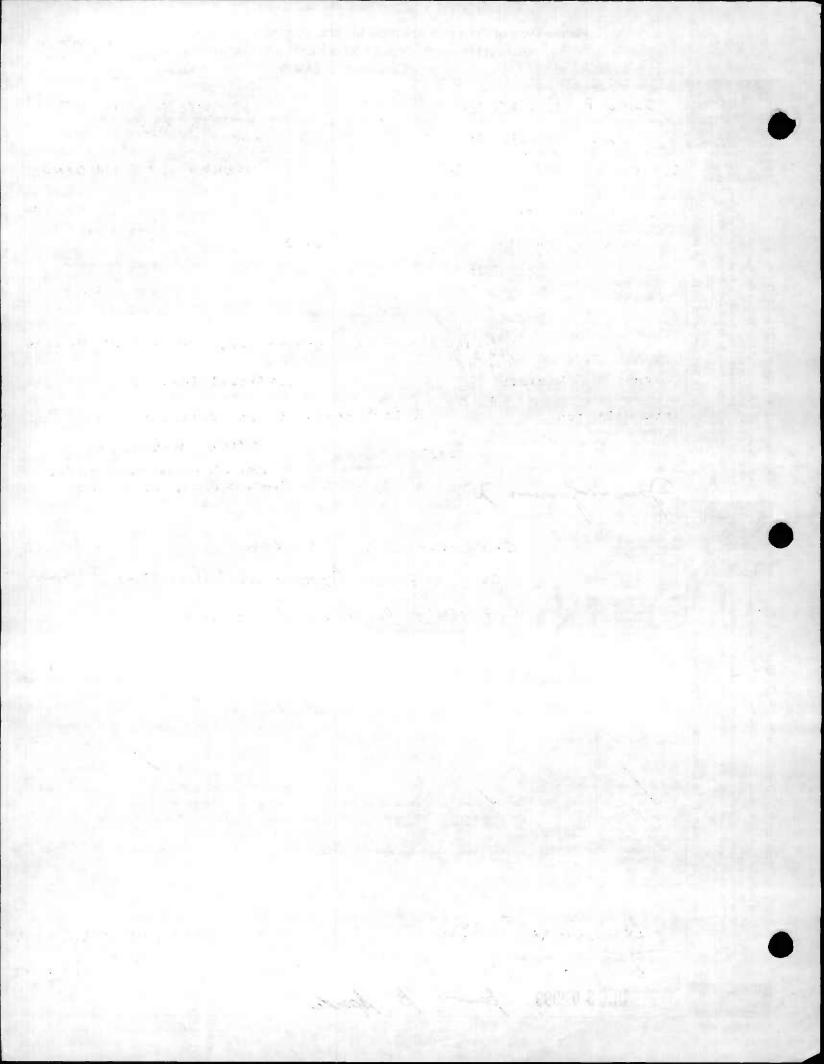
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Vear **Physician** 1130 PM JOHN P. DIPIETRO , 1999 December 26 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Baltimore HOSPITAT SINAI If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year Birthplece (Stete or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 5. Social Security Number 15M 2DF **Funeral** Deys Vrs October 18, 1944 Director 218-42-9042 Usuel Residence of Decedent with the Marylend 10d. Inside City Limits 10a. Stete 10c. City. Town or Location ral, or items 23s or 28s-f show Examiner must be notified at Baltimore 1 ☐ Yes 2 ဩ No Director MD 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Lark Meadow Ct. 21236 5 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Recs - American Indian 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Deportment of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or itel any injury or other traumatic avent, the Medical Examinations. 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Dates: 1 Never Married 2 N Merried 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) U.S. Food Service Corporate Credit Mgr. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Carmel DiPietro Phyllis DelGiuidice 19a. Informent's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Arta DiPietro 5 Lark Meadow Court, Baltimore, Md. 21236 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 St Buriel 2 Cremetion 3 Removal from State 12/30/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Oaklawn 22. Name end Address of Facility Joseph N. Zannino Jr. Funeral Home 21. Signature of Funerel Service Licenses 263 S. Conkling Street, Baltimore, Maryland 21224 Oseph Homenon e, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel CARDIDGENIC SHOCK disease or condition resulting in deeth) Examiner Due to (or as a consequence of): INFERIOR Myocardial INFARCTION Examiner law requires that the death certificate be executed physician end s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): CORONARY P.O. Box 68760 Physician/Medical Due to (or as e consequence of): signed by the a id be deteched for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24a. Wes en eutopsy performed? Completed been: has le 2 page The 2 PNo 1 ☐ Yes 2 ☐ No 1 TYes certificate 25. Was case referred to medical exempler?

1 ■ res 2 □ No Attending Physician: Be 26. Piece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral d 27. Menne of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No a Funeral Director: A bletely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 5 edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. (Check only one) To the To the To the I 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier Denammy V December 26, 1999 Pikesville 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Victor Du Bois GreenTree ROAD Maryland 21208 amin 1838 31. Dete filed (Mer. Cay, 102/1999

32. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

AMEND#8 PER MD. G786 8-4-2000 JABState of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death AMEND#1 PER MD. G778 12-29-99 J.A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 28 1999 BABY BOY DIGGS 01:20AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 8. Dete of Birth 9-28-99 (Month Day, Year) 6. Sex. 1 M M 2 □ F If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) **Funeral** Yrs. None Director Usuel Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notified at 1 Yes 2 □ No Director TIMOVE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 134 2120 Nerna 23a Hvenye Funeral Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indien, 11. Marital Stetus injury or other traumatic event, the Medical Examiner. 1 Never Merried 2 Married BIACK Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No natural', or Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene important: If Item 27 is marked other than eny injury or other traumetin. Elementery/Secondery (0-12) College (1-4or 5+) NA NA)/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surneme) Be unknown 0 41ang 19b. Mailing Address (Street end Number or Rural Route Number, City o Town, Steta, Zip Code) 19e. Informant's Name/Raletionship (Type, Print) Ho. Md. Wes QUIANA 20a. Mathod of Disposition mother 61 20b. Plece of Disposition (Neme of cemetery, cremetory or other p Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stata
4 Donation 5 Dothar (Specify) DIS posci timore sonns Lins Hos 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wolfe 5HH-600 Thuser 23s. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or have failure. List only one ceuse on each line. Approximete Intarvel Batween Onset end Deeth Ph sician Immediate Ceusa (Final disease or condition resulting in death) /Medical Examiner Dua to (or es e consequence of): Examiner : Hence Andrown KI physician and s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): UNKNOWN P.O. Box 68760, Physician/Medical Due to (or es e consequença of) for use Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Wes an autopsy page 2 1 Yas 2 No 1□ Yas 2□No or Attending Physician: director, Be 25. Wes case referred to medical axaminar? 26. Place of Daath (Chack only ona) Hospitel: 1 Impatiant Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this After thi 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Panding Investigation 1 Natural To the Mospital or Attendin within 24 hours after death. To the Funerel Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be datermined 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stele) 4 Homicida edical 29a. Certifier 1 🕒 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date end plece, end due to the ceusa(s) and mannar es statad. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 30. Nema and addrass of person who completed cause of death (them #3ar (Type, Print) ST BALTIMORE, MD 21287 LEVY MD NIKITA 600 NORTH WOLFE 31. Data filed (Month, Dey, Year) 32. Registrar's Signeture State DEC 29 1999 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** JOSEPH J. DRUSO 1999 DECEMBER 26 11:30 am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2006 LONGVIEW AVENUE ROSEDALE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) MAY 5 1909 5. Social Security Number 9. Birthplace (Stata or Foreign Country) PENNSYLVANIA 7. Age (In yrs. last birthday) **Funeral** Days 11 M 2□ F 90 Yrs. Director 216 12 9188 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Director 28a-f MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must b 21237 2006 LONGVIEW AVENUE USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Place - American Indian, Black, Whita, etc. 11. Marital Status 72 hours after 1 ☐ Never Merriad 2 ☐ Married 1 ☐ Yes 2 ☐ No ò 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elamantary/Secondary (0-12) College (1-4or 5+) STEEL WORKER STEEL 4 0 permit. Pages 1 and 2 should be file important of iteals and Mental Hyg important; if them 27 is marked other any Injury or other traumented other and Injury or other traumented other and Injury or other traumented other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be SUSIE KERECKY MICHAEL DRUSA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTORIA DERNOGA / DAUGHTER 2006 LONGVIEW AVENUE ROSEDALE, MD 21237 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) SACRED HEART OF JESUS 12/30/99 BALTIMORE, MD 21. Signatura of Funaral Sarvice Licenses CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellura. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical 61200 Sarcoma Examiner Physician/Medical Examiner The law requires that the death certificate be executed ician end buriel-trans Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): for use as the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 21 No 3 Probably 4 Unknown page 2 should be detect þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 21000 1 Tes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 8 25. Was casa raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Pesidence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 BNatural 5 Pending invastigation n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 4 T Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar completely

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Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

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Division

State Registrar 31. Data filed (Month, Day, Year) DEC 3 0 1999

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and titla of certifier

(Check only one)

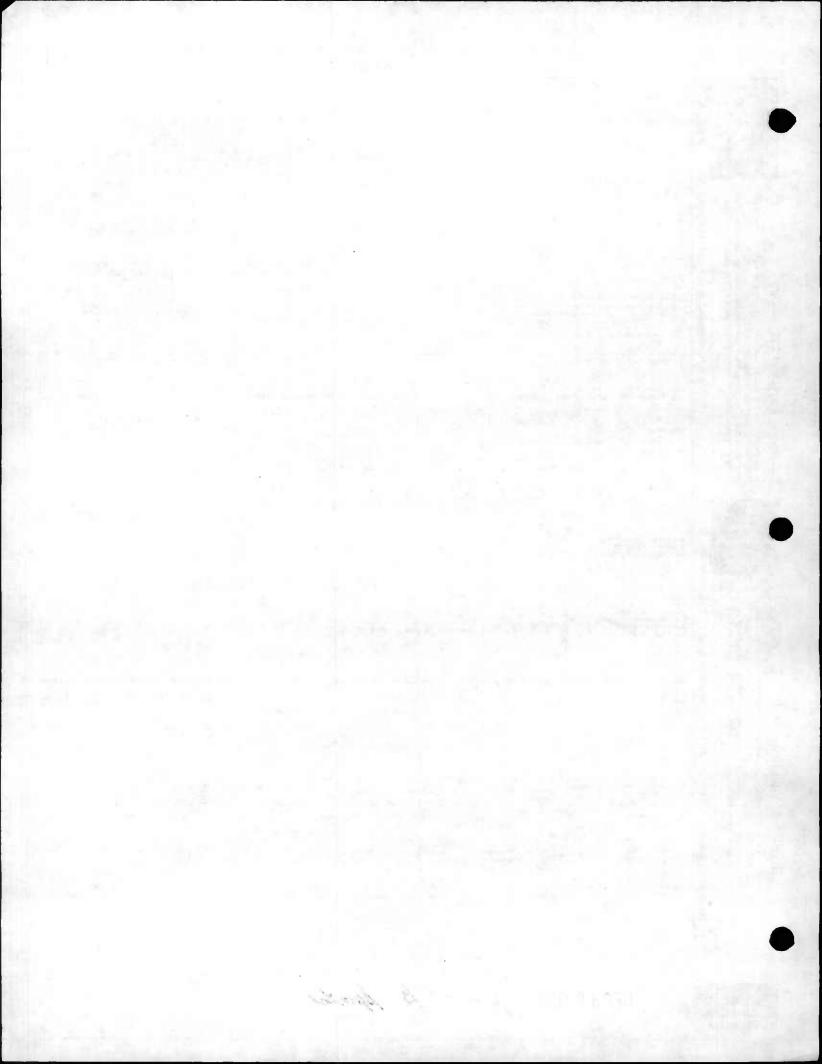
32. Régistrar's Signature

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1232 RACE KS. BALTIMORE, MD 21237 oorto

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM323a PER MD G778 12/30/99 AH Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth Month **Physician** 1300 Audrey Barnes Eaton 25 1999 Nov. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign
Country) **Funeral** 10M QF Days Yrs. Director 76 Oct. 22 1923 Maryland 216-14-8299 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2X No Director MD Harford Belair 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 300 W. Ring Factory Rd. USA 21014 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, Whita, etc. 72 hours after 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Nevar Married 2 □ Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16h Kind of Business/Industry filled within I Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Medical 12 n/a Maryland 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) of Health and Mental H I flam 27 is marked off is other traumatic even and 2 should be Arthur Gorman Barnes Florence (Unknown by informant) 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 2904 Anderson Rd., White Hall, MD 21161 Glenn Stevenson/Son Baltimore. permit. Pages 1 a Exportant of them: any injury or other 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Donat (Specify) Oaklawn Cemetery 11/29/99 Baltimore, MD 21. Signature of Poteral Se 22. Nama and Addrass of Facility Lemmon Funeral Home Lowell M 10 W. Padonia Rd., Timonium, MD 21093 Lemmon 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner RUPTURED CEREBRAL ANEURYSM Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaasa or injury thet initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? or algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings available prior to complation of cause of death? Completed 24a. Was an eutopsy performed? of Vital 25. Wes casa rafarred to medicat axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Impatient 25
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(Month, Day Year) 1 ☐ Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 2 Accidant 5 Pending invastigation 1 Yas 2 No 6 Could not be detarmined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

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Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sig

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

29c. License numbe

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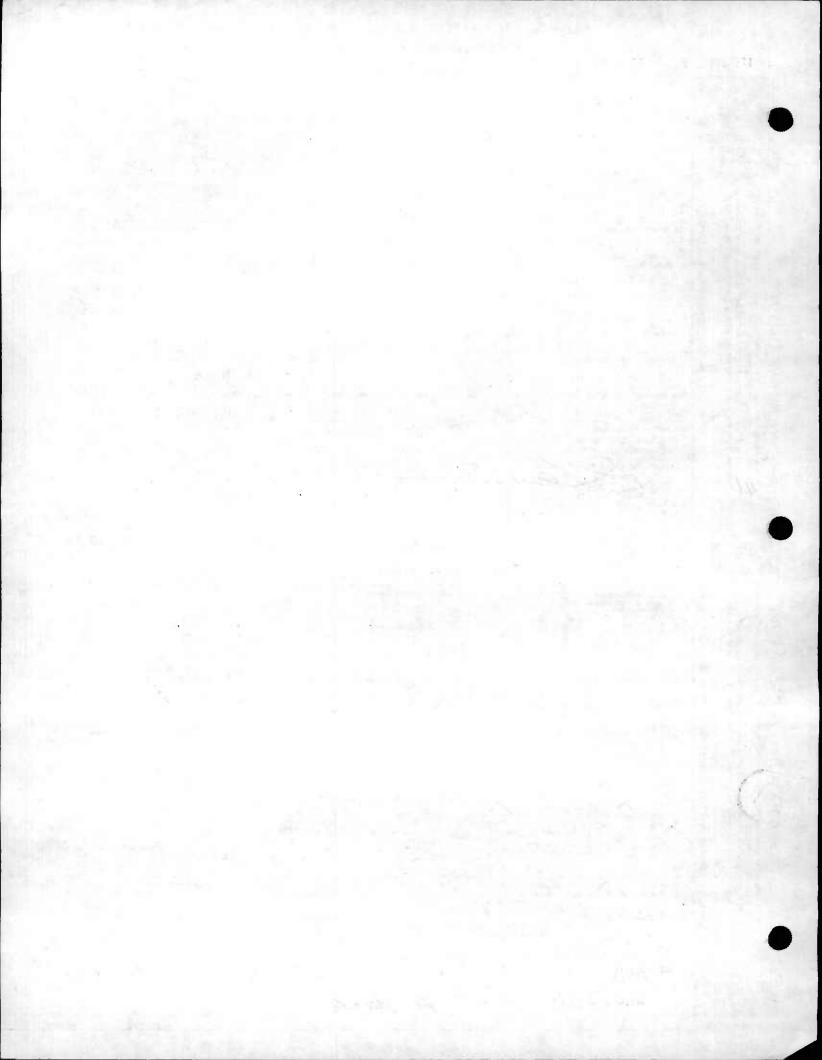
29a. Cartifian

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32: Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** O Q AMES 04:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner MARRYLAND UNIVERSITU OF HOSPITAL TIMORE 5. Social Security Number 241-62-682 8. Dete of Birth (Month, pay, Year) November 3, 1943 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Funeral Days 108M 20 F Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Marities Examines must be notify and apage. 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 WNo II Yes, Give Yes, G 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status 1 Never Married 2 Married wan 1□Yes 2010 21215-0020 Specify: Completed by 3 Widowed 4 Divorced merican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Model, Maiden Surname) Be 19a Informant's Neme 19b. Mailing Address (Street and Number or Rural Route Num) City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, cremetory or other p Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Pert1. Enter the disease, or complications that codes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner 0515 The law requires that the death certificeta be executed Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last for use as the bunal-tran-Due to (or es a consequence of): P.O. Box 68760. Due to (or as e consequence of): ate has been signed by the a pege 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3☑Probably 4☐Unknown Records, à 24b. Were eutopsy findings aveitable prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No Division of Vital er Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 11⊠Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural within 24 hours ofter death. To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. 2 ■ Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one)

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

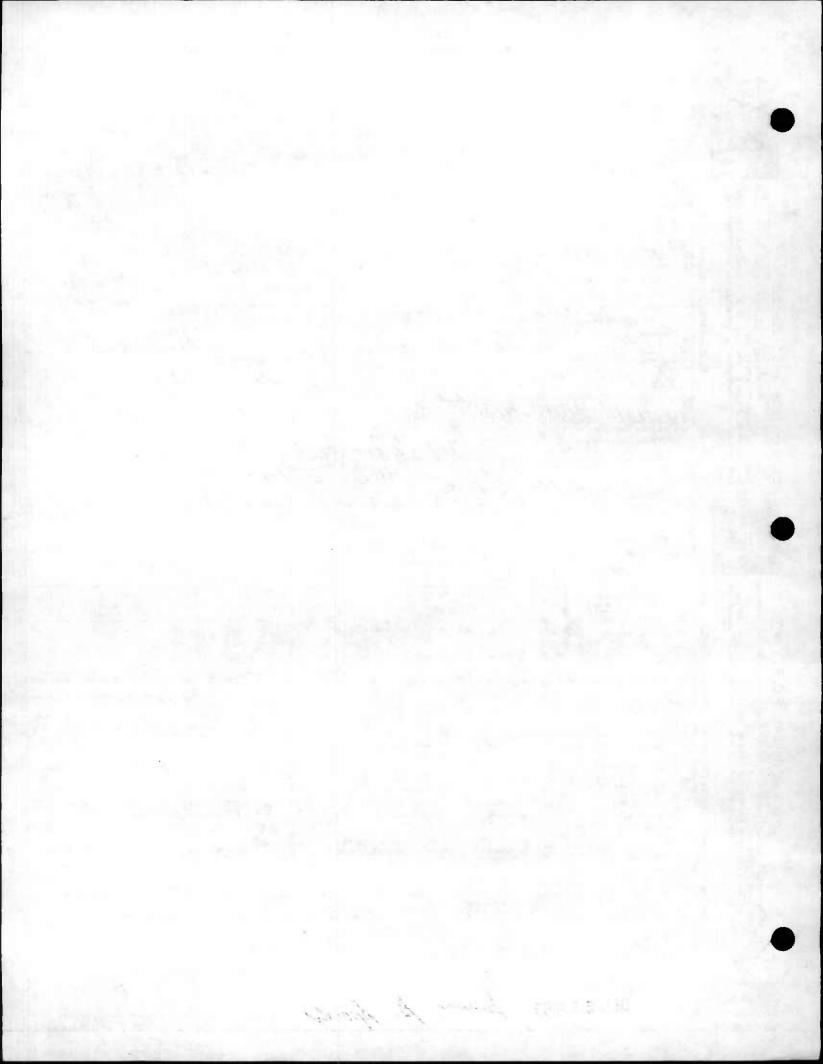
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30. Name and educess of person who completed cause of death (Item 23a) (Type, Print) aba

29c. License number

altimore, MD

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0855 Inez Feaster 29 1999 DE /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE aGNES N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 10XM 2□ F 77 Yrs. Director 251-38-7459 Aug 5, 1922 SC Usuel Residence of Decedent with the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits of feeling answers of Montal Hygiene.

Hem 27 Is marked other than "natural", or flores 23a or 28a-f ahov other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2X No Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2805 Diamond Ridge Road Apt. 204 21244 United States Funeral 12. Wes Decedent Ever in U,S Armed Forces? 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Merried 2 □ Merried 1 ☐ Yes 2 No If Yes, Give Year or Detes: Maryland 21215-0020 1 ☐ Yes 2 No Specity: Specify Š 3 ₩ Widowed 4 Divorced Black Completed permit. Peges 1 and 2 should be filed within 72. Department of Heelth and Mental Hyglene. Important: if Nem 27 is marked other than "natuons in jury or other traumatic event, the Mental Police." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Housekeeping Elementary/Secondary (0-12) College (1-4or 5+) Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Martin Willie Mae Farrow 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Carolyn Brooks-Daughter 2805 Diamond Ridge Rd. Apt. 204, Baltimore, MD Baitimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Jan 5 4 ☐ Donation 5 ☐ Other (Specify) St. Matthews Baptist 2000 Blair, SC 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility llos Smith & Williams Funeral Home, P.A. 2 2818 East Baltimore Street Baltimore, MD Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner SUFFICIF sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760 Physician/Medical Due to (or es a consequence of): been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown þ Completed 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? 5RONARY ISEA-SE 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2√ No 1 Unpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendivitin 24 hours after death To the Funeral Director: A completely filled in by the f 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature, and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 60 AGNES HOSP. 900 CATON OWUSY 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

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(Check only one)

29b. Signature end title of certifier

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31. Date filed (Month, Day, Year)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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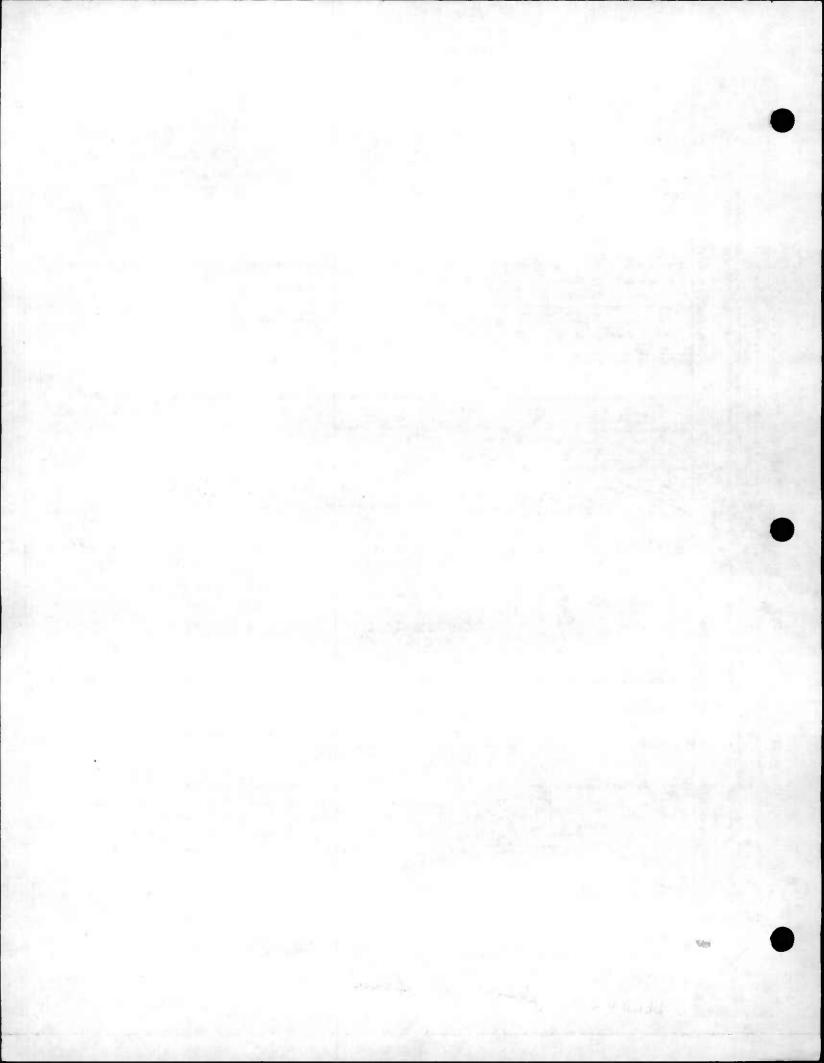
alner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29d. Date signed (Month, Day, Year) 15 CAMBER 57, 1999

BATTIMORE MARYLAND

29c. License number

Squire



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Day Vaar Month Physician Anita G. Gittens 21:50 DECEMBER 26 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 24 Hrs. if Under 1 Year Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 8. Deta of Birth (Month, Dey, Year) 06-08-21 7. Aga (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 20 F 78 Yrs 216-88-9758 Director Cuba Usual Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits I is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at XXYas 2 No Director MD NA Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? with 1 2934 Harford Road 21218 IISA Funeral Was Decedant of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 72 hours efter 1 Yas 2 XNo If Yes, Giva Yaar or Detas: 1 Navar Married 2 Marriad Maryland 21215-0020 1 ☐ Yas 2 No Spacify: Black Specify: p **¾**□ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry be filed within al Hygiene. Collaga (1-4or 5+) Elamantary/Sacondary (0-12) Domestic various trades 12th Grade NA 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) mit. Pages 1 and 2 should be fit partment of Health and Mental Hepotrant: If Hern 27 is marked other injury or other traumatic even Be Milton Morris Gill Agnes 2 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, State, Zip Coda) 10553 19a. Informent's Name/Ralationship (Type, Print) Ormond L. Morris 255 South Columbia Avenue Mt. Vernon, N.Y. Baltimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal State Voshell Mem. Gardens 01-03-2000 Dundalk, MD Other (Specify) any in 22. Nama end Addrass of Facility Baltimore, Maryland 21202 21. Signatura of Funeral Service Lic WM.C.March FH 101 E. North Avenue Approximeta Intarval Between Onsat and Daath 231 Farty. Entar the diseesa, or c shock, or heert feijura. List of the causad tha death. Do not antar the mode of dying, such es cardiac or respiretory errest, on each line. **Physician** Aviedicai immediata Causa (Final SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE disaasa or condition rasulting in daath) Examiner Due to (or es a consequence of). Examiner MULTIFOCAL ATRIAL TACMYCARDIA one month the death certificete be executed physician end stree burief-trans Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or injury that initiated evants resulting in deeth) Lest Dua to (or es e consequance of): P.O. Box 68760 Physician/Medicai Dua to (or es e consequence of) 98 use 0 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen pege 2 hes 1 Yas 2 No 1 ☐ Yas 21 No certificete Division of Vital director 25. Was casa rafarred to madical Be 26. Piece of Daath (Check only ona) axaminar? Hospitel: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this funeral 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascriba how injury occurrad Certification: 28b. Tima of After 1 Natural 5 Panding invastigation efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide Hospital or 24 hours e Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifian 29c. Licansa number 29d. Data signed (Month, Dey, Year) 2438946 Jecember 26, 1999 30. Nama and address of person with complated causa of daeth (Itam 23a) (Typa, Print) ROTHMAN AURIE P. UNION MEMORIAL HUSPITAL BALTIMORE, MD 21218

Registrar

State

31. Data filad (Month, Day, Year)

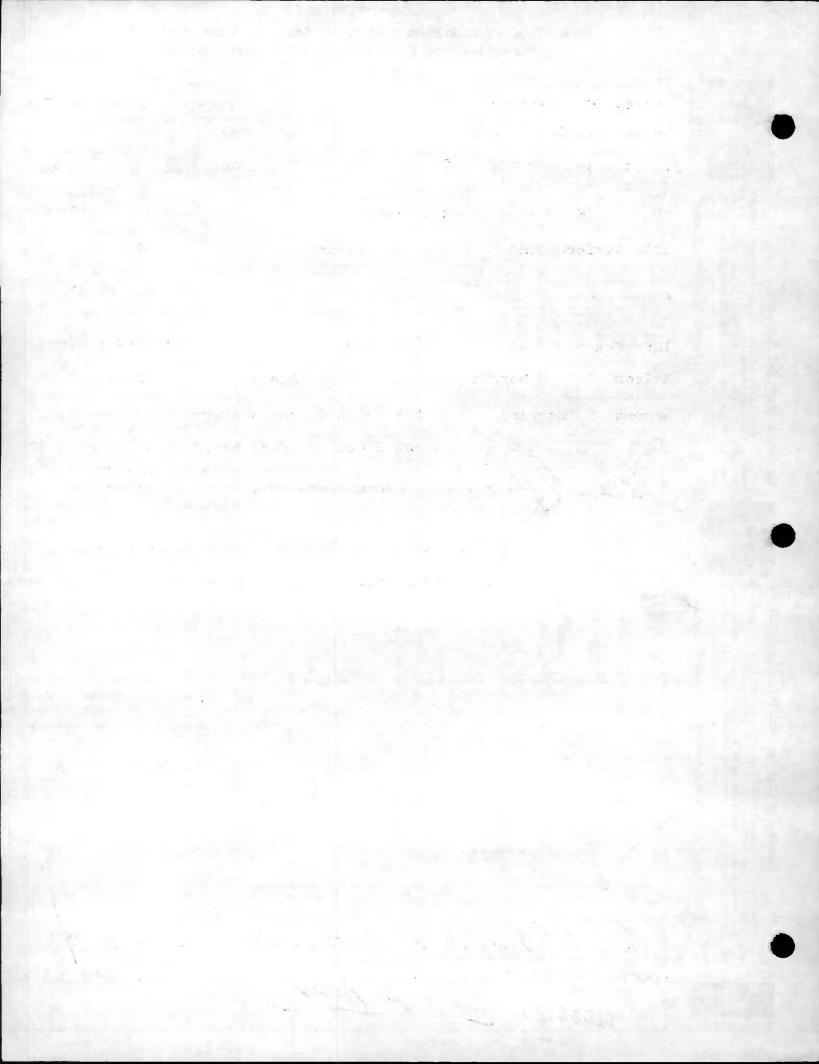
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32. Registrer's Signatura

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State of Maryland / Department of Health and Mental Hygiene Q Q 40907 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 26 1999 **Physician** Clarence Green 9:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Johns Hopkins Geniatrics Center If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** XXM 2DF 78 214-20-1837 Director January B. 1921 Usual Residence of Decedent deeth with the Marylend 10e. State 10c. City, Town or Location 10b. County 10d. inside City Limits If is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4918 Crenshaw Avenue 21206 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of the pages of the state of the site of the filed within 2 ls marked other than "natural", or iter any injury or other traumatic event, the Medical Examinations 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Maintenance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Willie Green Mallory Martha 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) 1620 E. Federal Street Baltimore, MD. 21213 Rosa Beatrice Lyon 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩DABurlal 2 Cremation 3 Removing Arbutus Mem.Pk. Cemetery 12-31-99 Arbutus, MD □ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 Funeral Service Licer WM.C.March FH 1101 E. North Avenue Part Filter the disease, or con-shock or heart failure. List only Approximete interval Between Onset and Death in caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Aspiration fueumonia immediete Cause (Finei disease or condition resulting in death) Examiner Hemorrhagic Cerebrovascular accident Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest physician and s the bunal-tran Division of Vital Records, P.O. Box 68760. Physiclan/Medicai Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 450 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 28c. Injury et Work? 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation or Attending efter deeth. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Mospital of 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

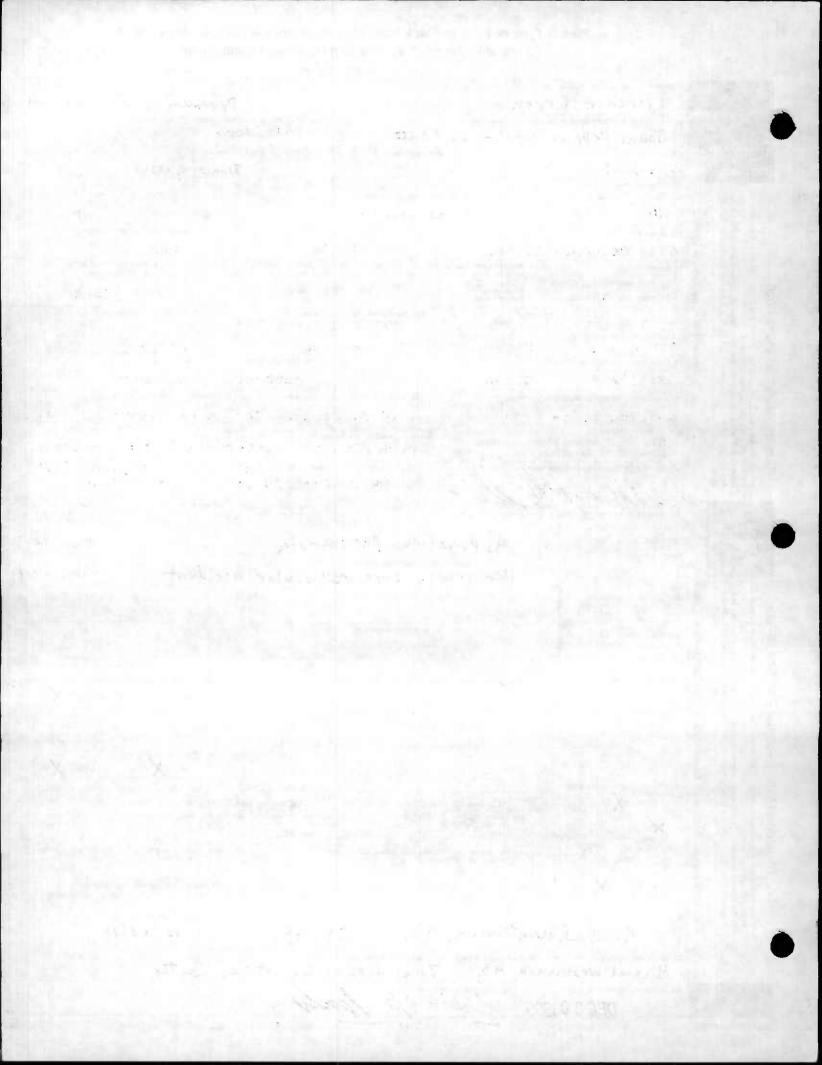
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier

Michael Westernan, M.D. 29c. License number 29d. Date signed (Month, Dey, Year) 12/27/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Geriatrics Center Michael Westerman M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

. Decedent's Neme (First Middle	Last)		Cen	ificate of	Death			eg. No.	99	3. Time of Death	
							Month	Day	Year		
		r)			4b. City. To			1		06:41an	
			ast birthday)		If Under	24 Hrs. 8.	Date of Birth			ce (State or Foreign	
	1□M 21xF	6	9 Yrs.	Months Deys	Hours	Min.	AN. 30	, 1930	MARY L	AND	
		10c. City	, Town or Loca	ation				-	100	d. Inside City Limits	
MARYLAND N/A		В	ALTIMOR	RE						1 ☐ Yes 🎾 No	
0e. Streef and Number				10f. Zip Code		49.5	10	0g. Citizen of \	What Country	y?	
3708 ANNAPOLIS ROAD 2								U	.S.A.		
1. Maritel Status	12. Wes Deceder Armed Forces	12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 X No If Yes, Give Year or Detes:			13. Was Decedent of Hispanic Origin? (Specify Yes on It Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☒ No Specify:				14. Raca - American Indien, Black White etc.		
1 Never Married 2 Marrie 3 分 Widowed 4 Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give							Specify: WHITE			
15. Decedent's (Specify only highest	Education grade completed)	ucation 16a. Decedent's Usur fe completed) (Give kind of wo			pation during most	t of working		16b. Kind of Business/Industry			
Elementary/Secondary (0-12)		College (1-4or 5+)						OMAT TICS	M TP		
7. Father's Name (First, Middle, L.	ast)	HOMEMAKE			18 Mother's Name /First Midn						
	В.	Н	ENRY		CLARA SNYDER						
9a. Informant's Name/Relationshi	p (Type, Print)	. ///	19b. Mailing	Address (Stree	t and Numbe	er or Rural Ro					
		()									
		00	ace of Disposi	tion (Name of	ice)	1 1 5	Date :	20c. Location -	City or Town	n, State	
		Э								. MD	
		CED									
1111	1 4 11										
23a. Part1. Enfer the disease, or c	omplications that cause	ed the deeth.				•			. A	Approximate	
Shock, or heart failure. List of	nry one cause on each	line.							C	nterval Between Onset and Death	
mmediate Cause (Finel	MET	ABOL	ic E	NCEP	HALO	DPATH	14			12 days	
esulting in death)	a					(30 E)					
110000	TYPE	TI	DIA	BETES	MEL	-LITU	S			10 YEARS	
Sequentially list conditions,						100				m1 . h =	
flany, leading to immediate cause. Enter Underlying Cause, (Disease or Injury C. CHRONIC RENAL FAILURE										FYEARS	
INT MINISTER GAGING		Due to (or as a consequence of):								2 11-0-1	
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art II. Other significant condition	lerlying cause of	ven in Part I.		23b. Did tobacco use contribute to the cause of death?							
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	panomedi							of de	pletion of cause		
							1□ Ye	s 212No	10	Yes 2□ No	
5. Was case referred to medical examiner?						of Death (C	heck only on	e)			
1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
1\□Natural 5 □ Pending		ay Year)	28b. Time of Injury				28d. Describe how injury occurred				
Z L AUGIGORIA	t he		М		1 Yes 2 No				0-4-11-1		
4 Homicide determin	200. PIBCB OT II	28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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29b. Signature and title of certifier 29c. License							25	9d. Dafe signe	d (Month, Da	ay, Year)	
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Nuteh None and address of person with the state of the s	no completed cause of	death (Item	23e) (Typa, Pr	ini) SAT	ISH	CHA	NIDR	. A			
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Enter Underlying Jause (Disease or Injury hast initiated events eause). The product of the Could not determined to the Could not th	Commendate Cause (Finel Isoses or completations shock, or heart failure. List only one cause on each mendate Cause (Finel Isoses or condition esulting in death) Last	e Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER Social Security Number 217-24-7067 Jesual Residence of Decedent 10a. State 10b. County 10c. City MARYLAND N/A 11 Wes Decedent Ever in U.; Armed Forces? 1 Test 2 Zin Not Hyes, Give Year or Detes: 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last) EDWARD 18 Linformant's Name/Relationship (Type, Print) ROSALIE HAHR De. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22a. Part . 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Sex 10 A 2 T 69 Yrs. 10 C. City, Town or Lock 10 C. State 10 C. County 10 C. City, Town or Lock MARYLAND 10 State 10 C. County 10 C. City, Town or Lock MARYLAND N/A BALTIMOR 8. BALTIMOR 10 State 10 C. City, Town or Lock MARYLAND N/A BALTIMOR 10 State 10 C. City, Town or Lock MARYLAND N/A BALTIMOR 11 Sex 2 No 11 Yes, 3 No 12 No 13 No 14 Deather (First, Middle, Last) 15 DWARD 16 Deather (First, Middle, Last) 17 Burial 2 Comments on 3 Removal from State 18 Deather (DAUGHTER) 19 Sex Informant's Name/Relationship (Type, Print) 19 Surial 2 Combet (Specify) 10 Deather (Specify) 10 Deather (Specify) 11 Yes 12 Signature of Funeral Service Licensee 12 Sequentially list conditions, lary, leading to immediate cause (Fine) 18 Sequentially list conditions, lary, leading to immediate cause (Fine) 18 Sequentially list conditions, lary, leading to immediate cause (Fine) 19 Sex Informant's name/Relationship (Type, Print) 10 Due to (or as a conseque cause, Enter Underlying and Indeath) 10 Due to (or as a conseque cause, Enter Underlying not eath line. 11 Sex Order of Death (Print) 12 Sex Order of Death (Print) 13 Sex Order of Death (Print) 14 Death (Print) 15 Due to (or as a conseque cause, Enter Underlying not eath line. 16 Death (Print) 17 Per I Dia (C. City, Town or Lock 17 Per I Dia (C. City, Town or Lock 18 Sex Order (Print) 28 Due to (or as a conseque cause) 29 Due to (or as a conseque cause) 20 Due to (or as a conseque cause) 20 Due to (or as a conseque cause) 21 Sex Order or Death (Nonth, Day Year) 22 EP/Outpatient 23 Due to (Or as a conseque cause) 24 Death (Print) 25 Death (Print) 26 Death (Print) 27 Death (Print) 28 Death (Print) 28	Decedent's Name (First, Middle, Last) ALICE JEAN GUERRA e Facility Name (It not institution, give street and number) HARBOR MOSPITAL CENTER Social Security Number 217-24-7067 6 Sex 7 Age (In yrs. last birthday) 1 Market Social Security Number 217-24-7067 6 Sex 7 Age (In yrs. last birthday) 1 Market Social Security Number 217-24-7067 6 Sex 7 Age (In yrs. last birthday) 1 Market Social Security Number 218-24-7067 6 Sex 7 Age (In yrs. last birthday) 1 Market Social Security Number 3708 ANNAPOLIS ROAD 1 Market Status 1 Named Forces? 1 Never Married 2 Married 3 R Widowed 4 Divorced 1 Never Married 2 Married 1 Never M	Decedent's Name (First, Middle, Last) ALICE JEAN GUERA e Facility Name (If not Institution, give street and number) HARBOR HOSPITAL CENTER Social Security Number Sex 217-24-7067 Sex 218-24-7067 Sex 218-2	Decedent's Neme (Frist, Middle, Last) 2	December Name (First, Middle, Last) December Name (First, Middle,	Doesdorfs Norm (First Michiga, Last) Doesdorf Day Dec Cell Market Dec Cell	Debt of Death Day 2 Very December Street (Pitz, Modes), Leat)	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month LENORA GALL D ECEMBER 22, 9991 0655A1 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death the first and number,

HOPKINS BAHVIEW MEDICAL CENTER BALTIMICAL
ber 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Months Days Hours Min. 2-23-14) 4c. County of Death Examiner BALTIMURE 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 212-07-2389 Director MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "netural", or itema 23a or 28a-f shorthe Medical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Baltimore Director N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1246 Delbert Avenue 21222 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 Year or Detes: "netural", or items Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mentel Hygiene. Important; if item 27 is marked other than "ny any injury or other traumatic avant, the Meganone. Elementery/Secondery (0-12) College (1-4or 5+) Sales Lady Reads Drug Store 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Hrica Lenore Slezak 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Stephen Gall 1246 Delbert Ave., Baltimore, MD 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremetion 3 ☐ Removel from State Sacred Heart of Jesus12-27 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home auri 1201 Dundalk Avenue, Baltimore, MD 21222 23a. Pert1. Enter the disease, or copylications thei caused the deals to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 10 DAYS SEPTICEMIN Examiner Due to (or as a consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in dealh) Lest Due to (or es e consequence of): ettending physicien for use es the buria Box 68760 certificate be Physician/Medical Due to (or es a consequence of): P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISTASE Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy BELOW KNEE AMPUTATION 1 Yes 2 No 1 Yes 2 No certificate Division of Vital director Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To this 28c. Injury at Work? 27. Menner of Death 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred I or Attending P after deeth. Director: After t 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide - Euneral Dietely filled in Hospital

Registrar

edical

29a. Certifier

(Check only one)

29b. Signeture end little of certifier

DEC 3 0 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

DR. MARIAMA SEMEGA-JANNEH, JOHANS 2. Registrade Signetura

HOPKINS BAYVIEW MEDICAL CENTER

29d. Date signed (Month, Day, Year)

DECEMBER, 22, 1999

DHMH 16 Rev 6/95

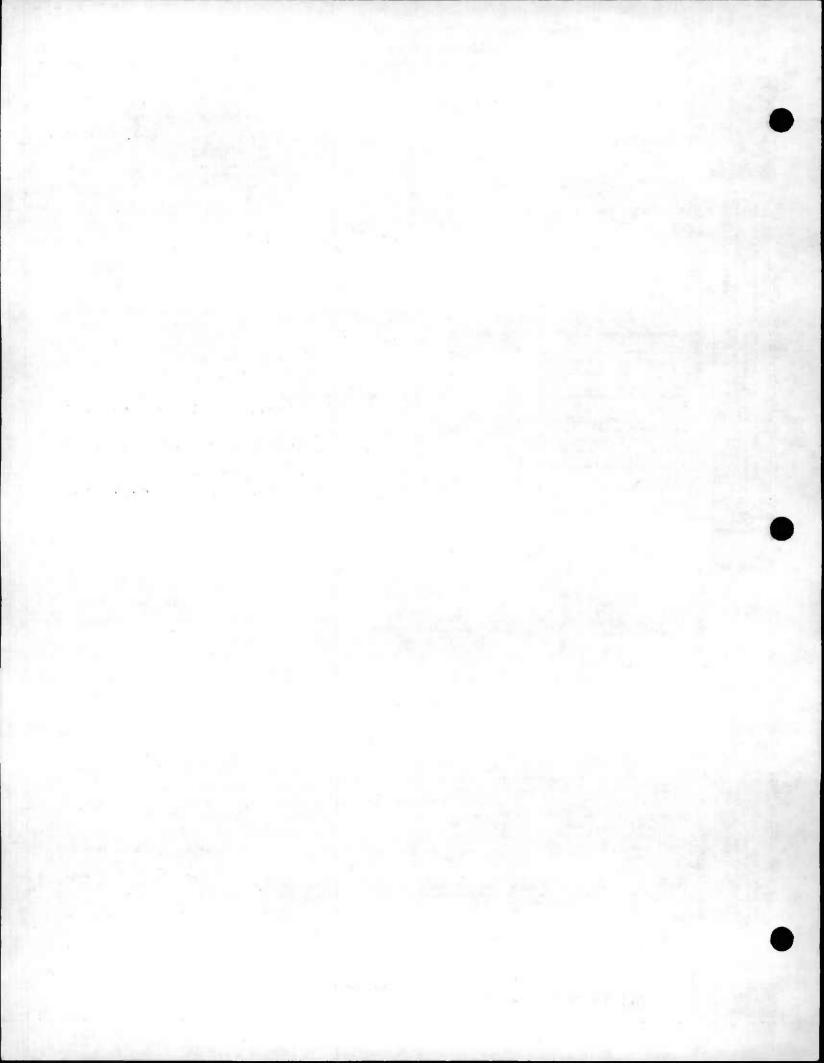
To the Hosp within 24 hou To the Fune completely fi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end menner steted.

29c. License number

98031 THBMC



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month **Physician** 3 JUCE STELLA December 25 1999 0530 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore City Baltimore City ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) November 5,1918 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Yrs 215 07 5765 **Director** Baltimore, Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore County Nerre 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4614 Ballygar Road 21236 USA Funeral permit. Pages 1 and 2 should be flied within 72 hours after deal Department of Health and Mantal Hygens. Important: If Item 27 is marked other than any Injury or other training ones. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 1 Yas 2X No Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Rusiness/Industry Elementery/Secondery (0-12) College (1-4or 5+) NA Homemaker Housekeeping-Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William J Stiner II Grace A Bacon 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Carol A Rego (Daughter) 4614 Ballygar Road Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State Moreland Memorial Park December 28, 1999 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nome end Address of Fecility
Lassahn Funeral Home, Inc.
7401 Belair Road Baltimore, Maryland 21236 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart fellure. List only one cause on each lina. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finel disaase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Physician/Medical Examiner PERUDOMONDS 57 1 or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): physician s the buria P.O. Box 68760. Ischemic Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. PV 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 ☐ Yes 20 No 1 ☐ Yas 2 € No certificate Division of Vitai funeral director 25. Was casa refarred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 patient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 10 this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending s after death. 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicida 24 hours a Hospital 29a. Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

State Registrar

To the To the To the F

DHMH 16 Rev 6/95

(Check only one)

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29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

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SA SRA

30. Name end address of person who completed causa of deeth (Itam 23a) (Type, Print)

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32. Registrer's Signature

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) and menner stelled.

29c. License number

P 11390

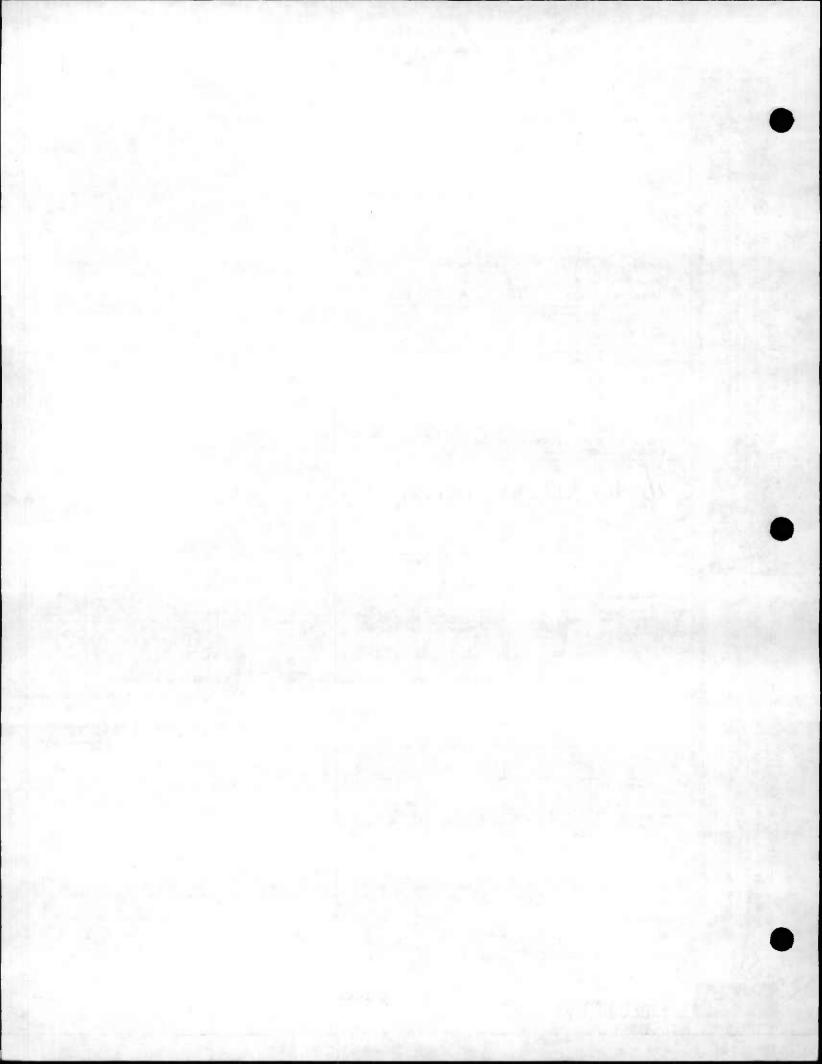
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29d. Dete signed (Month, Dey, Year)

BLUD

December 25, 1999

BALTIMORS NO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GOREN Day DECEMBER 26,1929 12:15 PM **Physician** LILLIAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTH WEST PANDALLS TOWN HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) JULY 15,1915 Birthplace (State or Foreign Country) 6. Sex **Funeral** 10 M 20 F Days Hours 217-05-5716 Yrs. 84 Director Usual Residence of Decedent 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3334 KERRY ROAD 21207 U.S.A. 14. Race - American Indian, Black, White, atc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or less any injury or other traumetic event, the Medical Examiner 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Vland 21215-0020 1 Yes 2 No Specify: WHITE 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **HYMAN** SCHUMAN SARAH **OPPAS** 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MYRON GOREN / SON 3334 KERRY ROAD - BALTIMORE, MD 21207 altimore. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MEN CEMETERY 12/29/99 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervat Batween Onset and Death **Physician** Immediate Causa (Final disease or condition rasulting in death) · MULTI ORGAN FAILURE /Medical 28 DAYS Examiner Due to (or as a consequence of): CANDIDA SEPSIS Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown ADENO CANCINOMA, SIGMOID Records, 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 20 No 1 Yas of Vital or Attending Physician: 8 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospital: y Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 ☐ Yes 2 ☐ KSO Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation i Director: Aft of in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atla within 24 hours effer de To the Funeral Directo completaly filled in by th 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. | Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DECEMBER 26, 1999 37333

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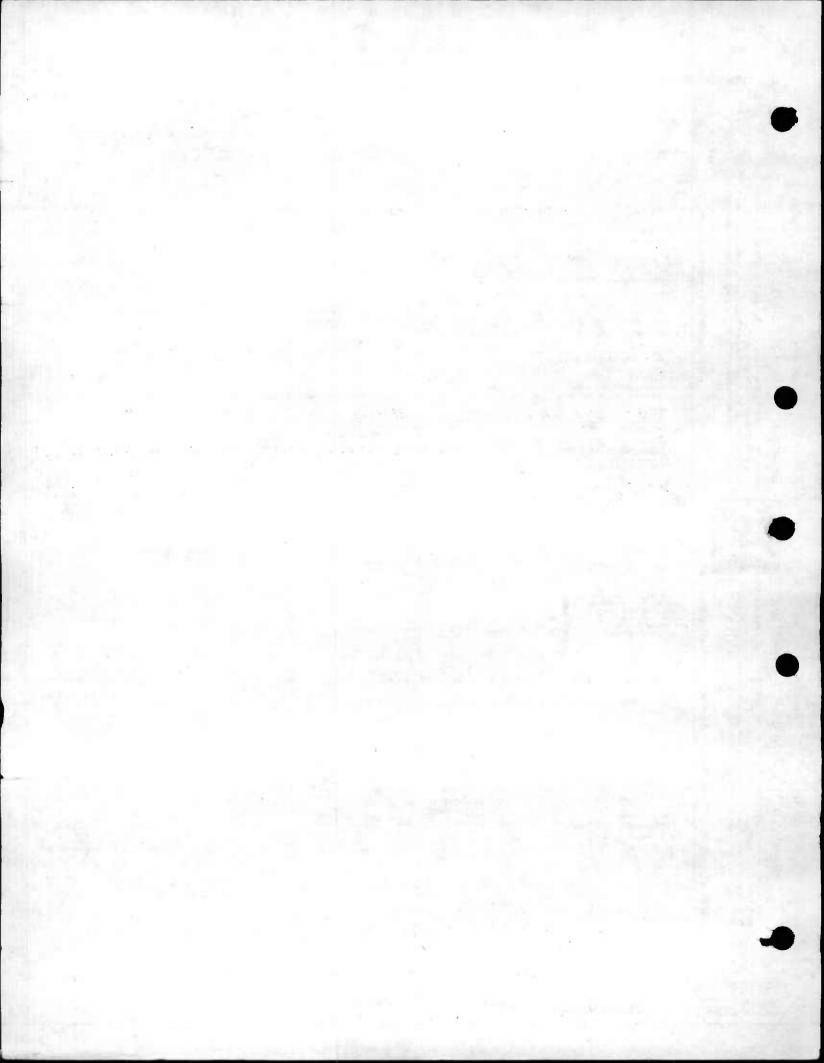
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO,

31. Date filed (Month, Day, Year)

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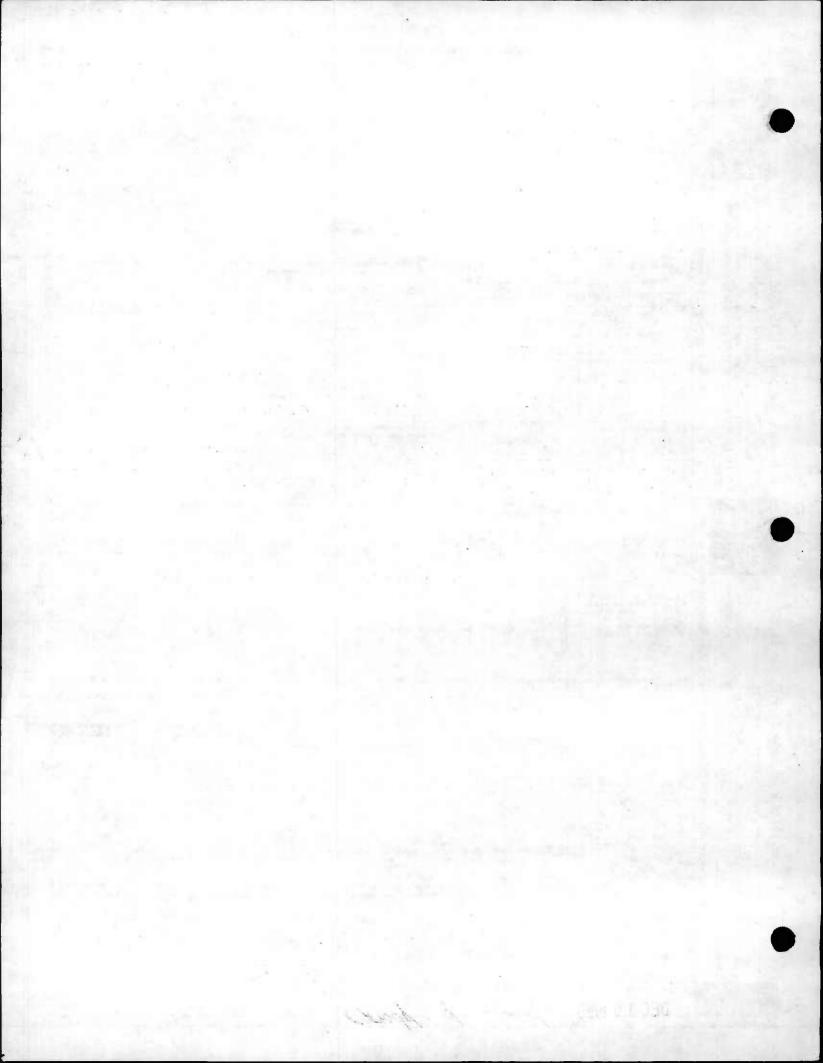
32, Registrar's Signatura



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State of	State of Maryland / Department of Health and M Certificate of Death	Re	g. No.	40912							
Physicia	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year 200							
/Medica	BERNICE W. GASKINS	12	-	799 8:15 Pr							
Examine		ocation of Death 4c. County of Death									
	LEVINDALE NURSING CENTER BALTIMO		N/A								
Funeral Director	5. Social Security Number 219-18-1795 6. Sex 1 M 2CVF 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 4-5-23	Year)	9. Birthplace (State or Foreign Country) MD.							
show	Usual Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location 10d. Inside (
vith the Maryle or 28a-f shore	MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code	1		1 🖾 Yes 2 🗆 No							
With the		10	10g. Citizen of What Country?								
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020 oz	1042 RUXTON AVE. 11. Marital Status 1			White, etc. BLACK							
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be file of the out.	17. Father's Name (First, Middle, Last) 18. Mother's Nam	nme (First, Middle, Maiden Sumame)									
should be od Mental marked o		JONES									
■ D = L =	19a. Informant's Name/Relationship (Type, Print) VIVIAN FORNEY (DAUGHTER) 19b. Mailing Address (Street and Number or Ru 1642 RUXTON AVE. BAL'	IARYLANI	21216								
2 8 2 2 0	20e. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 4 Donation 9 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MT . ZION CEMETERY 20c. Location - City or Town, State 12-29-99 BALTIMORE, MARYLAND										
Baltimo	21. Signature of Funeral Service Licensee 22. Name and Address of Facility PH 1721-27 N. MONROE S'		,								
68760, Ifficate be executed Examiner. Sprysician and es the burial-transit	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Batween Conset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
I Records, P.O. Box (The law requires that the death certifies has been signed by the attending page 2 should be detached for use a											
O de de	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tot	oacco use con	tribute to the cause of death?							
P. d by	El (Enebrovasidar disease	1 □ Ye	e 2□ No	3 Probably 4 Wilknown							
ds, Ids, Ids, Ids the signed d bedge				(
Cord Cord V requir		24a. Was an autopsy performed?		24b. Were eutopsy findings evailable prior to completion of cause							
Rec Has has be had be h				completion of cause of deeth?							
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Of Vital Physician: T	1 ☐ Yes 2 ☐ No Hospitel: 124mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 ☐ Resider	nce 6 □Othe	r (Specify)							
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= X2+c	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Division Content of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral particulars of the funeral particular of the funeral particulars of the funeral particular of the fune	29a. Certifier (Check only one) 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated. (Check only one) Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.										
To the Within To the Committee Commi		of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)									
3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
State											
Registra	DEC 3 0 1999 Severe & Sports										

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GUNZELMAN Day **Physician** Month LAURA Dec 21 11999 2135 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colonial Burnie 6452 Knoll Anne ALUNDAC Glen if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 D Days 218-14-0577 Yrs. Director MD Feb 27, 1924 Usual Residence of Decedent 10a, State show 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f sh MO ANNE Alunda Glen BUINIE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 Colonial 160011 6452 r than "natural", or items 23a U-SIA Funerai death 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Wh. to Completed by 3 Widowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hom HomeMAKEr NIR traumatic event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 Is marked oth-any linjury or other traumatic event ORDS. 18. Mother's Name (First, Middle, Maiden Sumame) Be Catherine Charles emchuck Bunger 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hooson BALD. MD 2604 21724 Charles GUNZELMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State V.A. cemetery 12/27/99 c Rowrsuille 4 ☐ Donation 5 ☐ Other (Specify) Crowsville 22. Name and Address of Facility 21. Signular Funeral Service Licansee HARTLEY Miller Fragel Home & HTD. BALTO MO 21234 7527 Halford RD 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) heart /Medical Arterioscolorific Examiner Due to (or as a consequence of): Physician/Medicai Examiner The law requires that the death certificate be executed the bunial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Records, þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has been 1 ☐ Yes 2 🖼 📆 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1⊠LYes 2⊟ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendil within 24 hours efter death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

William . ()

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30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

JONES

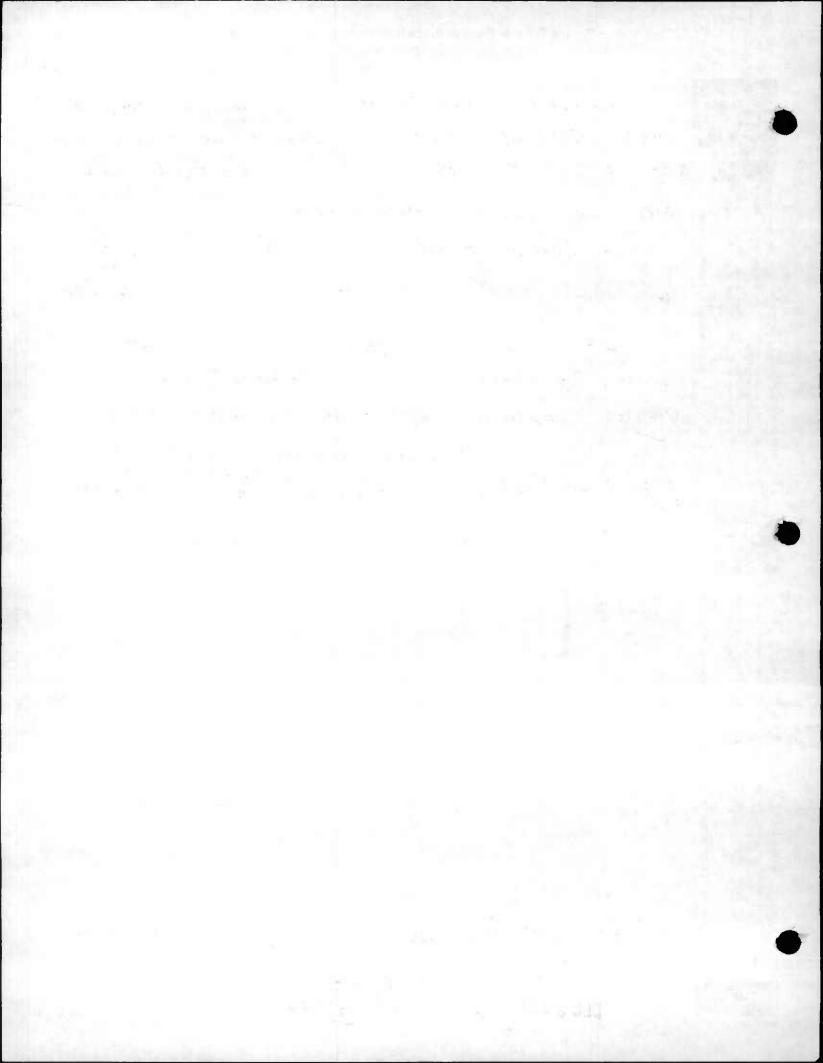
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32. Registrar's Signature

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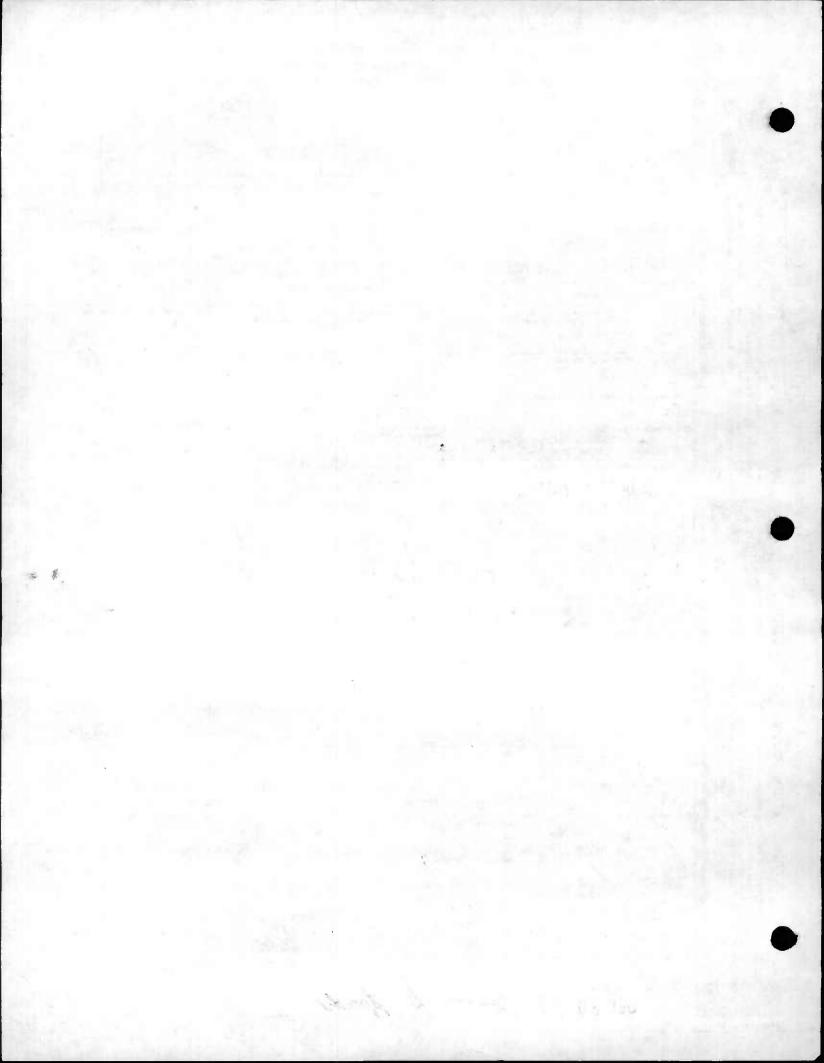
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death DESWINDER 27, 1999 **Physician** Anita Louise Hawkins /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2□E Months 218-78-9488 Yrs. Director June 22, 1958 Md. Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. tnaide City Limits Md. n/a 1 Xes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1617 N. Longwood Street 21216 238 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Giva XX Year or Dates: ò 1 Yes 2 No Specify Specify: Black ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry mentary/Secondary (0-12) College (1-4or 5+) 12th Grade Typist Social Security Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Important: If Item 27 is merked oth any Injury or other traumatic event alose. Claude Hawkins Irene Brown 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice Hawkins 1617 N. Longwood Street Baltimore, Md. 21216 sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removat from State 4 Donation 5 Other (Specify) Western Star Cemetery Jan. 4 Baltimore, Md. 22. Name and Addrass of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funaral Service Licensee nutter 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart feiture. List only one cause on sech lina. Approximete Intervat Batween Onset and Deeth **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical CARNIO PULMONARY ARREST Examiner Due to (or as e consequence of): RIGHT HEART FAILURE Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PULMONARY

Due to (or es e consequence of): P.O. Box 68760, ERYTHEMATOS .. LUPUS 5YSTEMIC Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Viahetes should be defi Records, þ 24b. Ware eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1. Yas 1 Yes 2 No 2 No Division of Vitai Attending Physician: 25. Was case referred medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2E No 1 Inpatient Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Menney of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Hospital or Attanding
 24 hours after deeth.
 Funeral Director: After the funeral bit of the funeral price of the funeral pr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, atreet, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and dua to tha ceuse(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to tha cause(s) end manner stated. 29a, Certifier pletely (Check only one) To the l 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) December 27, 1999 Victor 029391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poen a min Victor DuRois 1838 Green Tree Rd Pikosville Mary land 21295 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State. DEC 3 0 1999 Registrar

DHMH 16 Rev 6/95

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B.K.S State of Maryland / Department of Health and Mental Hygiene MACK HINES Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year Physician Wallace DEC. 22, 1999 1115 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2300 WHEATLEY DRIVE BALTIMORE If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 219 66 6891 Yrs. MD Director **Usual Residence of Decedent** Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hyglane.

The file of the first of the file of the of the file of the fi 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f aho the Madical Examinar must be nothed at BALTIMORE 10 Yes 2 No Funeral Director mD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S 4506 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Specify: BLAL 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working Jife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENICES Paintenance 12 17. Father's Name /First. Middle. Last: 18. Mother's Name /First. Middle. Maiden Sumamel Or 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) md. 21215 1+INES Lmother 4506 Fernhill 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Data 1 Burial 2 ☐ Cremation 3 ☐ Removal Irom Stata BALT, md. permit. Page Department of Important: If eny Injury or page. Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22 Name and Address of Facility BALT, MD tome uner 21213 0 1129 avoline 23a./Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician s the burial P.O. Box 68760. Due to (or as a consequence of) been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2/2/10 1 Yes 3 Probably 4 Unknown of Vitai Records, by 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? page 2 : Yes 2□ No Yes certificata Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XXOther (Specify) AT SCENE Hospital: Certification: To XX Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28s. Date of Injury (Mighth, Day Year) 28b. Time of After Division 1 Natural 5 Pending investigation s after death.

I Director: After the further the second to the further the further the second to the further the second 22 1 ☐ Yes 281. Location (Street and Number or Rural Route Number, City or Town, State) 99 00 2 ☐ Accident 6 Could not be detarmined 3 Suicide intitro eco larm, street, factory, office Ath 3 Place offiniting At home building, etc. (Specify) Homicide ere 200 Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Difference on the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier withing To the F complet 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign ture and title of certifie O.C.M.E DEC. 23, 1999 d address of person who completed causa of death (Item 23a) (Type, Print) ARON We NO 111 Penn Street, Baltimore, Maryland 21201 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 16 Rev 6/95

1999

ORIGINAL

38.000

DHMH 16 Rav 6/95

Registrar

DEC 29

1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** FLORENCE HUDGINS DECEMBER 1999 /Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex N/A CIT JOHNS If Under 1 Year 8. Date of Birth (Month, Day, Year, 10-31-30 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 69 Yrs. 230-36-4909 VA. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnslde Clty Limits Barns 23a or 28a-f short 1 Nes 2 No Director MD. BALTIMORE N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1352 HOMESTEAD ST. 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -12--0-DOMESTIC HOUSEWIFE permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: if Nem 27 is mented other any Injury or other tra 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENNIE WIGGINS ESTELLE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2625 E. PRESTON ST. BALTIMORE, MARYLAND 21213 DELORES WILLIAMS (DAUGHTER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-28-99 BALTIMORE, MARYLAND KING MEMORIAL PARK 22. Name end Address of Fecility REDD FUNERAL SERVICE 21. Signature of Fyneral Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 200 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CHOLANGIOCARCINOMA H MONTHS Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Records, P.O. Box 68760, physician Physician/Medicai the Due to (or as a consequence of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown ped p by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ / Ne certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation n 24 hours after deeth. • Funeral Director: After detaily filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hour 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number INTERN

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

SALDMEH

DEC 3 0 1999

32. Registrar's Signature

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) KEYHANI

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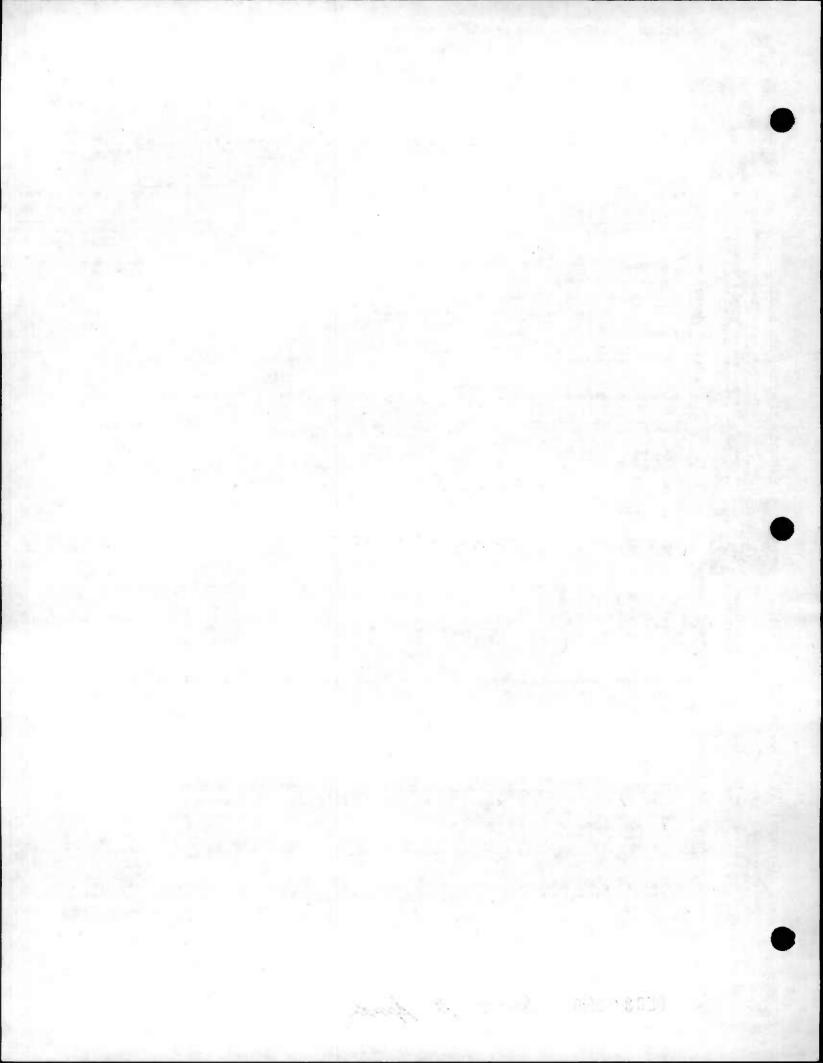
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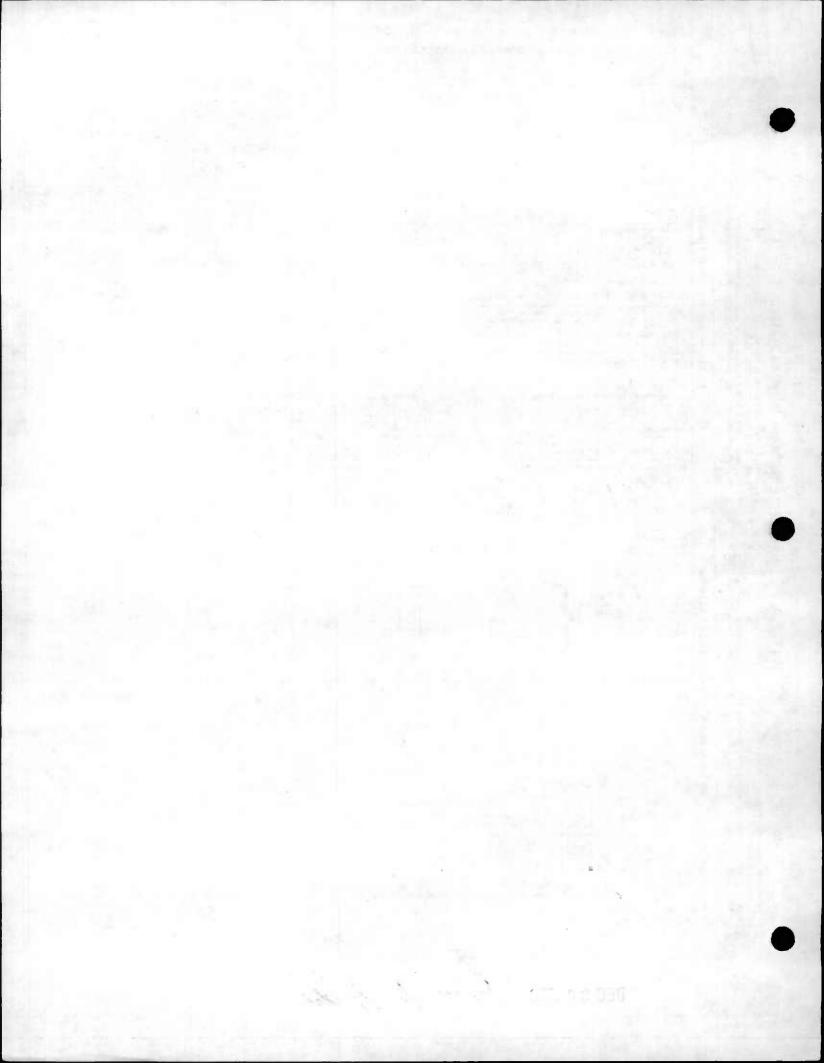
301 N CAROLINE STREET

DECEMBER 23 1999

TOANS HOPKINS HOSPITAL



Physician /Medical Examiner uneral irector	Decedent's Name (First, Middle, Last Edna Watkins Janka Facility Name (If not institution, give	")					-	Reg. No.				
/Medical Examiner uneral					2. Date			3. Time of Death				
Examiner uneral	4a Facility Name (II not institution, give					Decer	1 00 100	9 Year	5:40 PM			
_		street and number)				4b. City, Tow	n, or Location of	Death 4c. Count	y of Deeth			
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	5. Social Security Number 6. Se 214–22–7369	M 2XIF	e (In yrs. last bii 71	Yrs. Months		Hours	Min. (Mon	of Birth th, Dey, Year) 26, 1928	9. Birthplac	e (State or Forei		
ector	Usual Residence of Decedent		/ 1				Feb.	20, 1920	Baltimo	ire, Ma.		
Tall Tall	10a. State 10b. County		10c. City, Tow	n or Location					10d	. Inside City Limit		
diffe.	Maryland Baltimon				1 ☐ Yes 2 ☒ N							
be notified	10e. Street and Number			10f. Z	ip Code			10g. Citizen of	What Country	?		
must.	15 Collingwood Road	40 Man Danadant	Francis II C	42 Was Dag	2113		-0 /0	United S	tates of			
*natural", or itama 23a or 28a-f shor sideal Examiner must be notified at leted by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give		If Yes, sp			in? (Specify Yes Puerto Rican, et	Bla Specif	ck, White, etc			
al E	15. Decedent's Edu	Year or Dates:	16a	. Decedent's Us	uat Occur	nation		16b. Kind of B	White			
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To B	George Watkins Edna Dacan											
I them 27 is marked other that it other traumatic event, the life. To Be Comp	19a. Informant's Name/Relationship (T)	-	City or Town, State, Zip Code)									
har t	Mr. Martin Janka, Jr. (S	on)				rive Co		sville, Md. 21030				
# To	20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	cemete	of Disposition (Na ry, crematory or	other pla	-	Date	20c. Location - City or Town, State				
nlury	4 Donation 5 Other (Specify)							/1999 Timon				
any and	21. Signature of Funeral Service Licens	f- Ja	. Gair	22. Name a	ina Adare	ess of Facility		on Funeral Ho Rd. Towson,				
sician edical miner	Immediate Cause (Final disease or condition resulting in deeth)											
physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as a	consequence of):			A DE LOS	- 1			
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signed by the attending to be detached for use a by Physician/M	Part II. Other significant conditions con	inouting to death b	ut not resulting i	n the underlying	cause gn	ven in Part t.	230	1 Yes 2 No				
cate has been signe page 2 should be of Completed by		Wes en autopsy performed?	availa	autopsy findings able prior to eletion of cause								
has Pe 2	18 X X T T T							1 ☐ Yes 🛣 No	of dec			
ž o	25. Was case referred to medical					26 Pince	of Deeth (Check		101	′es 2□ No		
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E =	27. Manner of Death 1 2Neturel 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da)		Time of Injury	28c. Inju		28d. Des	5 Residence Control HOSPICE Describe how injury occurred				
Funeral Director: Attent etely filled in by the funeral dical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injubuilding, etc		arm, street, facto	ry, office	28f. Loca City	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
Funer tely fill lical	29a. Certifier 1 Certifying Physical Control one) 2 Medicat Exami	sician: To the best of ner: On the basis of end menner ste	examination an	a, death occurre d/or investigatio	d at the ti n, in my c	me, date and opinion, death	place, and due to occurred at the	o the cause(s) and m time, dete and placa	anner as state, and due to th	ed. e cause(s)		
To the comple	29b. Signature and title of certifier			25	9c. Licens	se number		29d. Date signe				
	147-				D4	3725	-	12/	30190	î		
7.7	30. Name and address of person who co	empleted cause of d	eath (Item 23a)	(Type, Print)						3 113		
O	DR. TARIQ MAHMOOD			ALLEY R	D. '	TIMONI	UM, MD 2	1093				
State Registrar	31. Date filed (Monte Dev. Year) 19	The second second second	ar's Signature	B. d.	Dock	21						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 12 27 **Physician** ARDENIA BAIRD **JONES** 1999 9:35PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MULTI MEDICAL CENTER TOWSON BALTO. If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 8. Data of Birth (Month, Day, JUNE 8, Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2□ F 85 Yrs. 216 16 4377 Director NC Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Director MD BALTO. TURNERS STATION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 PINE ST. 21222 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yas, Give Yaar or Datas: 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 Naver Married 2 Married 3altimore, Maryland 21215-0020 b 1 ☐ Yes 2 No Specify: Specify: BLACK p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry filed within Elemantary/Secondary (0-12) College (1-4or 5+) NURSES ASSIST HEALTH permi. Pages 1 and 2 should be file Cepartment of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be **JAMES** GLOVER MAMIE JEFFERS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) DONALD JONES/SON 829 CLOVERLEAF CT. EDGEWOOD, MD. 21040 20a. Mathod of Disposition

1 N Burial 2 Cramation 3 Ramoval from Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State Donation 5 Othar (Specify) MD. NAT. MEM PARK 1/3/00 LAUREL MD 21. Signatura of Funaral Sarvice Licensee 23 Name and Address of Facility & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217 M 23a Pirt1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) KENOSCERUTEC CANDIOVASCUCAN DIS Examiner Dua to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed for use as the burial-tran-Sequantially list conditions, if any, laading to immadiata causa. Enter Undartying Cause (Disaasa or injury that initiated avants rasulting In death) Last Dua to (or as a consequence of): P.O. Box 68760. Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Onknown is certificate has been signed by director, page 2 should be detac Division of Vital Records. Be Completed by 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? completion of ceuse of death? 198 1 Tas 25. Was cesa ratarrad to made a 26. Place of Death (Check only ona) Other: Certification: To 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) this the funeral 27. Marroy of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Panding s after death. 1 Yes 2 No investigation 2 Accidant 6 Could not be datarmined the Hospital or Attention 24 hours after deathe Funeral Director mpletely filled in by the 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homlcida Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and dua to the ceusa(s) and mannar as stated.

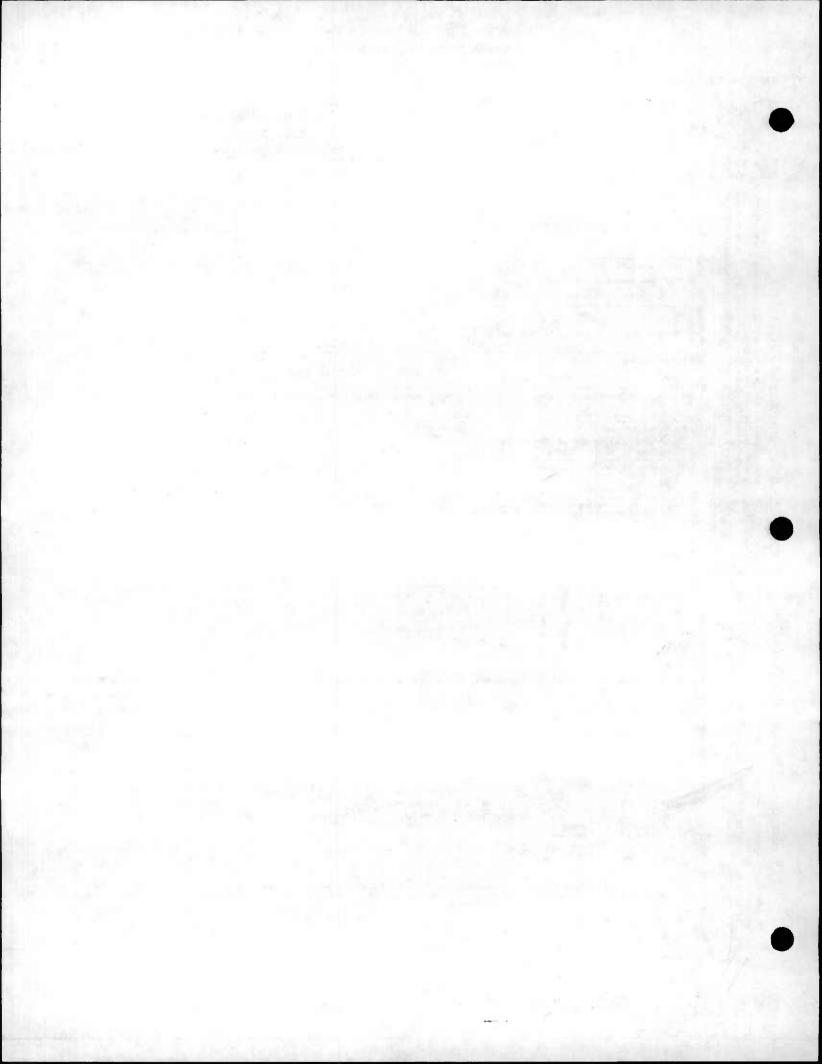
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. Medical 29a, Cartifiar (Check only one) within 2 To the ŝ 29b. Signatura and titla of certifia 2 and addrass of person who complated causa of death (Item 23a) (Type, Print) OMUT-31. Dela filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

DEC 3 0 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Henrietta H. Jones Dec. 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bon Secour Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) 1 M 2 X Days 217-18-6929 77 Yrs March 9, 1922 SC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 Tropes 2 □ No 10e. Street end Number 3045 Seamon Avenue 10f. Zip Code 10g. Citizen of Whet Country? 21225 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give XX Year or Detes: 1 Never Merried 2 Married 1 Yes 2 XXX Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Clerk Social Sec. Admin. 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Henry Henley Elmira Wright 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence C. Jones Husband 3045 Seamon Avenue Baltimore, Md. 21225 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forrest VeteransJan. 3 Owings Mills, Md. 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses Kerbert 2501 Gwynns Falls PKWY Baltimore, Md. 21216 nutter 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) lester Cardio Vosular Disease Due to for as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Wunknown Cancer, 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of deeth? 1□ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Md.

Director

Funeral

Director

"natural", or items 23a or

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "ns any injury or other traumatic event, the Media pose.

Maryland 21215-0020

Saltimoré,

Physician/Medical à Completed Be Certification: To

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifie (Check only one)

and physician been signed by the should be detached certificata

The law requires that the death certificate be executed Records, P.O. Box 68760. Division of Vitai To the Hospital or Attending Physician:

When Et Pors after death.

To the Funeral Director: After this carifficancemplement filed in by the funeral director; I

> State Registrar

Medical

29b. Signature and title of certifie

29c. License number

D /75 3 7

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, Stele)

28d. Describe how Injury occurred

30. Neme and eddress of person who complet ted cause of death (Item 23a) (Type, Print) DARSHAN.S. SA LUJA MD

28a. Date of Injury (Month, Day Year)

e) (Type, Print) MOUNT Royal Ave Ralto 2/2/7

31. Date filed (Month, Day, Year) DEC 3 0 1999

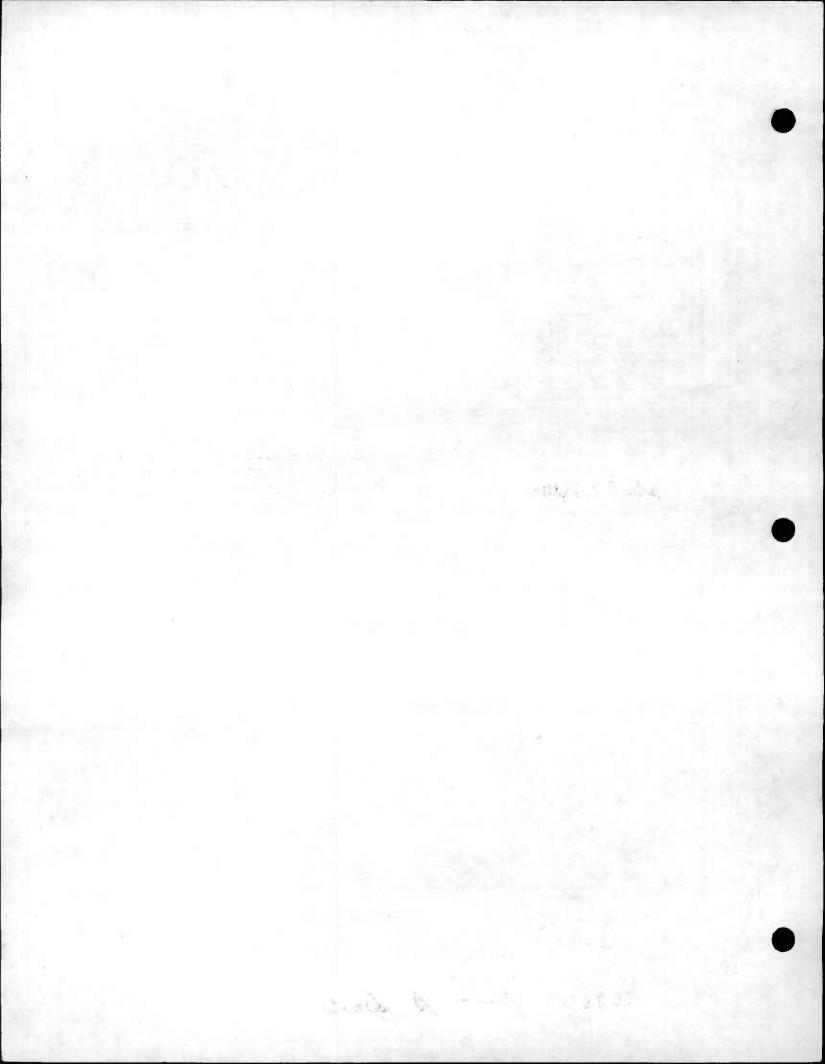
5 Pending

6 ☐ Could not be

32 Registrar's Signeture

28b. Time of

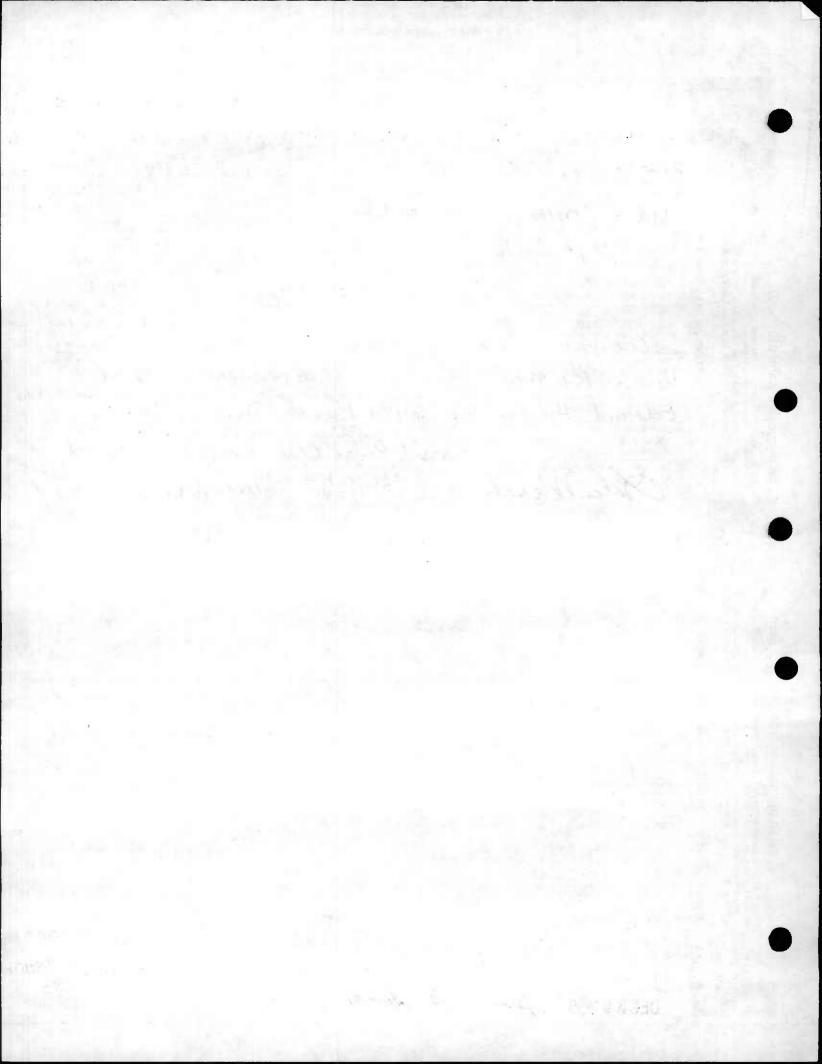
28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Julius December 28, 1999 Kose 150 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deel 4e Fecility Neme (If not institution, give street end number) Examiner Randallstown, mary land Hospital Morthwest Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Days Hours Min. (Month, Dey, Year) 9. Birmplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 212-34-3416 1 M 2 F Md Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Randallstown 1 Yes 2 No Balto Funeral Director Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 Hout 21130 U.S.A 9937 234 irde 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Dates: 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Maritel Stetus e filed within 72 hours aftar el Hygiena. I other than "natural", or ita 1 Never Merried 2 Married Maryland 21215-0020 Specify: Black 1□ Yes 2 No Specify. 2 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementery/Secondery (0-12) College (1-4or 5+) Service lerk 12th grade NA permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked othe eny Injury or other traumatic event, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) KUSSIN leanord Kie 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2/075 19e. Informent's Neme/Reletionship (Type, Print) 6439 Hughes - Son El Kridge, Md 20c. Location - City or Town, State Rux Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Ridge -3-2000 4 □ Donetion 5 □ Other (Specify) Ce 21. Signeture of Funeral Service Licensee 21215 22. Name end Address of Facility Hu Ba Ho M d

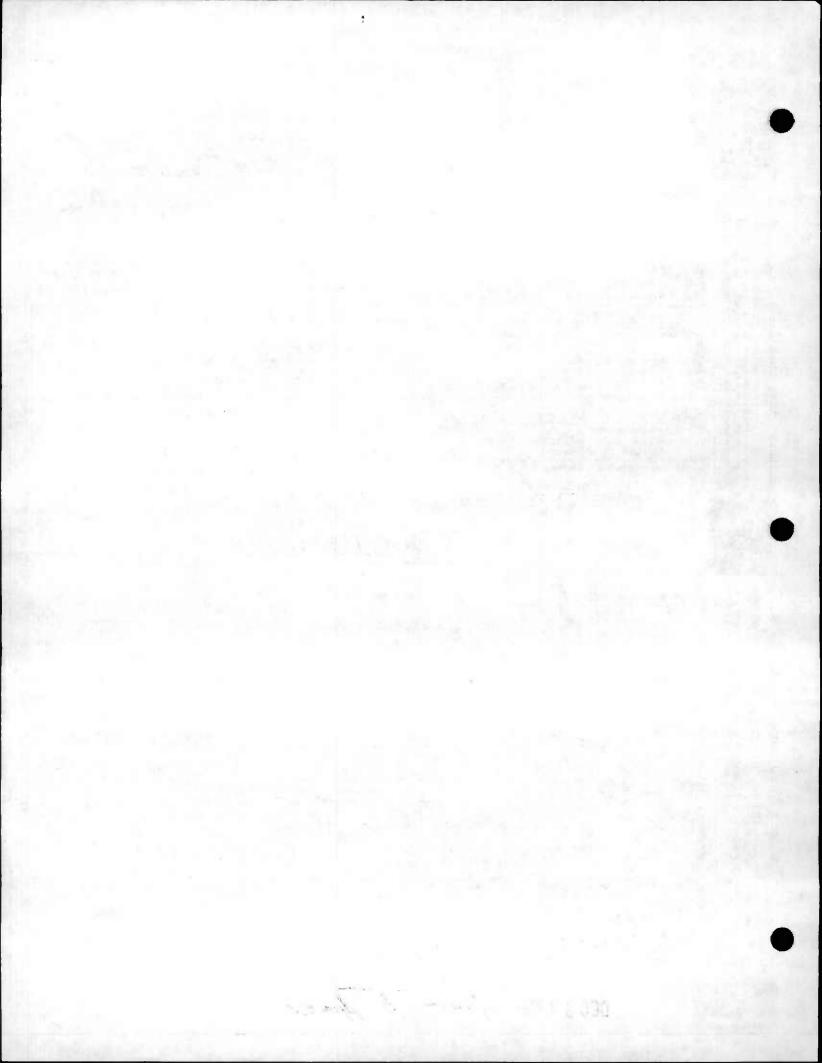
Approximate
Interval Between
Onset and Death 300 waspast 9 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Final hung Cancer diseese or condition resulting in death) Examiner Due to (or as a consequence of): be executed attending physician and for use as the burial-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): 56x 68760. Physician/Medical Due to (or es e consequence of) death cartificeta signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ension by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy peed hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funaral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 5 Pending investigation Hospital or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte compliately filled in by the fun 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end menner es stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner steted. 29e. Certifier (Check only one) 29b. Signeture mulitle of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 28,1999 eccumus V0052760 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 5401 old court Road RandallStour obin Muldrow crica maryland 31. Date filed (Month, Day, Year) 32. Registrer's Signatore State DEC 3 0 1999 Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 0.0

				Otato of Maryi			e of Death		Reg. No.	4092	.6.				
	W		I. Decedent's Name (First, Middle, Last		2. Date of De	ath	3. Time of	Death							
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9	Examine	4	la Facility Name (If not Institution, give		1420		4b. City, Town, o	Location of Death							
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	ter des Items	ָרַ בַּ		12. Was Decedent Ever in Armed Forces?	10,8.	If Yes, spe	Specify Yes or No rto Rican, etc.)	- 14. Hace Black	ce - American Indisn, ck, White, etc.						
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lar	Menta Menta	0	FREDERICK STEIN UNK												
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al E	Semit. Pe Separtmer mportant: iny Injury atica.	2	21. Signature of Funeral Service License	90 /	GLANE	22. Name ar	d Address of Facility	الم والمحمل المراسم	Hame	CHID					
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	es the de be de	- 6	Derella												
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Division of Vital	delen: The lecentificate he rector, page		25. Was case referred to medical				26. Place of Dr	eath (Check only o							
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	To the Hospital or Attending Physical Wilhin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dimension of the funeral dimension of the funeral dimension. To the funeral dimension of the funeral dimension.	9		building, etc. (Spe	uny)			City or Tov	m, olete/						
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	withii To the company		9b. Signature and title of certifier			290	. License number		29d. Date signed (Month, Day, Year)						
	.6		Cumlan	un h	n .		16619		DEC. 22	1999					
	17	30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) C. VERGARA - SOARES 2320 BENJON AVE, BALT, Md. ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature ACC 2 0 1000 Arrows & Manual Avenue Aven													
			C. VERGARA - SO	ARES 3	320	BENSE	ON AVE	BALT	Md. 2	1227					
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State of Maryland / Department of Health and Mental Hygiene 40923 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth **Physician** DEC. 28, ANNA R. KACZMAREK 1999 6 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 819 S. LUZERNE AVE. BALTIMORE If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 10/20/12 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Devs Hours 1□ M 22 F 214-03-1751 87 Director MD. Usual Residence of Decedent 10c. City, Town or Location or 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD. N/A 1 Yes 2 No BALTIMORE the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 819 S. LUZERNE AVE. Items 23a 21224 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Itan 27 is marked other than 27 any injury or other traumers. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Married 2 Married 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) PRESSER CLOTHING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 JOHN KACZMAREK 2 REGINA PIELA 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. REGINA HARTKA/NIECE 7611 WILHELM AVE. BALTO., MD. 21237 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 Burlel 2 □ Cremetion 3 □ Removal from Stete HOLY ROSARY CEME. 12/31/99 DUNDALK, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury ettending physician and for use es the bunel-trar Division of Vital Records, P.O. Box 68760, Physician/Medical thet initiated events resulting in death) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco uee contribute to the cause of deeth? signed by the 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? completion of ceuse of deeth? certificete has 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: effer death. Director: After this certifice Be (25. Was cese referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth in by the funeral 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ANaturel 1 ☐ Yes 2 ☐ No Z ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hoapital C 24 hours 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medicai To the To the To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Day, Year)
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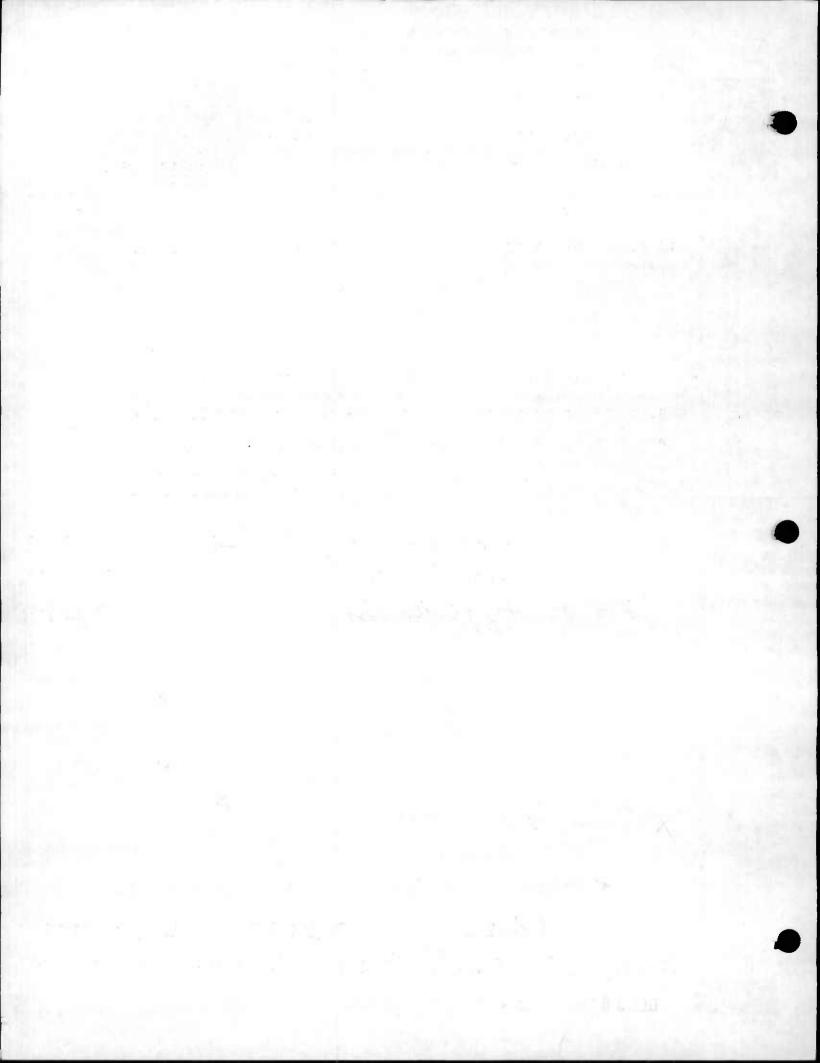
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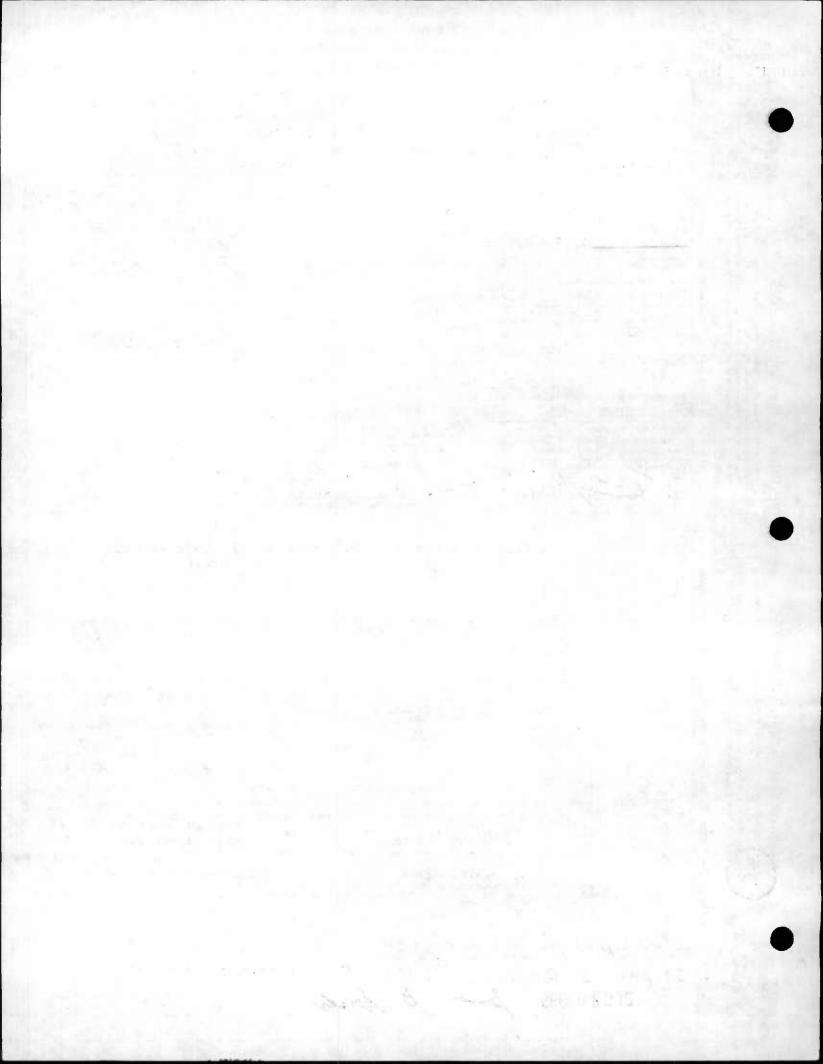
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Baltimore na 21224



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1	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility CAFA Stephen D. Lohmenn, P.A.												The Miles			
Element Tr. Father Harli 19e. Inforr Carol 20a. Matho 1 XB 4 D 21. Signal	\leftarrow	tha disafes, or complications ther caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on sech line. Approximate Interval Between														
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Calvin 29, 1999 George Lambert Dec 1:30am 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson
If Under 24 Hrs. B. Baltimore If Under 1 Year B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Days 11XM 2□ F Vist 218-05-3905 81 Nov 27, 1918 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Ridgefield Road 21093 USA 12. Wes Decedent Ever in U.S.
Armed Forces?
1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates 942-43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 01 Engineer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Watson George Lambert Viola Henrietta Schuchardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 3 Ridgefield Road, Lutherville, MD 21093 Mrs. Calvin G. Lambert/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns, 12/31/99 Timonium, Maryland 21. Signature of Fundral Services Co. 22. Name and Address of Facility Lowell M. enno Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD kemmon 21093 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death 77 Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest araw myo Be Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes all No

1 Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Not Sul 1 Yes 212 No 27. Menner of Death 1 Naturel 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifies 29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed

MM C 6101 31. Dete filed (Month, Day, Year) DEC 3 0 1999

egistratis suppliere Space BMTIMORE MO 21204 32. Begintrár's Signature

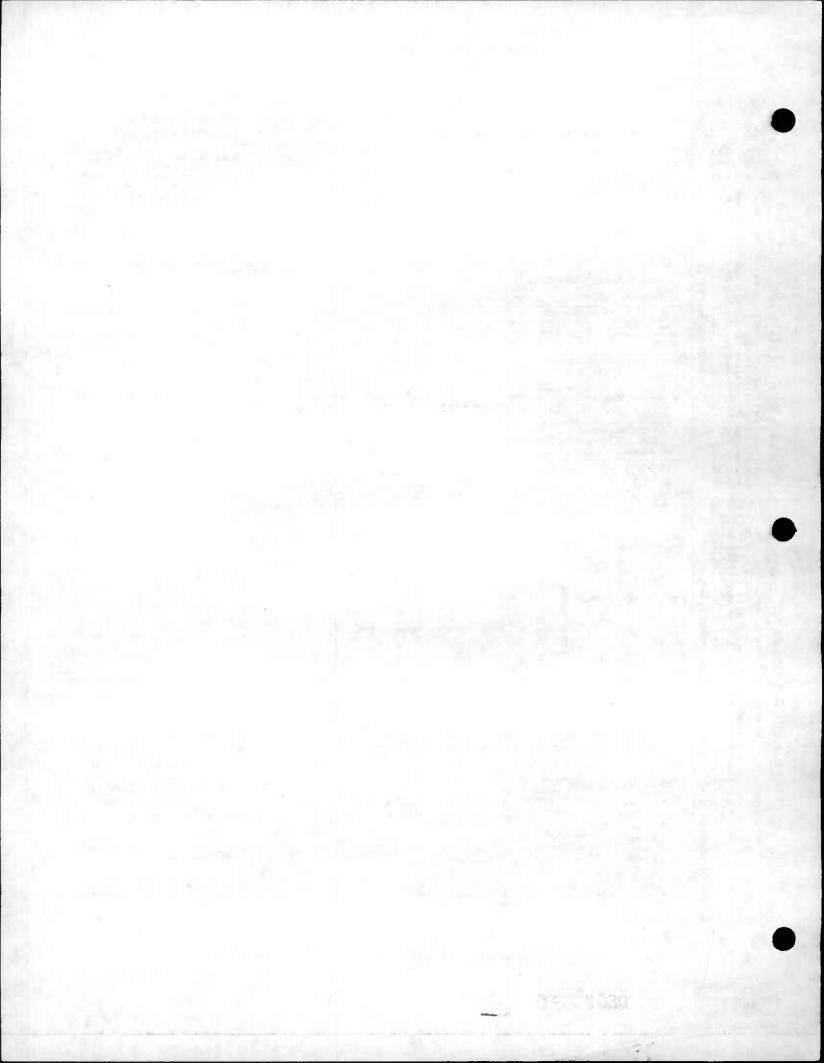
Registrar

Certification: To

Medical

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9

		A THE STATE OF	Certific	ate of	Death		Reg. No. 99	4092	26		
Physician	1. Decedent's Name (First, Middle, Las		2. Date of Dea Month	Day		of Death					
/Medical	ECULPA 4a Facility Name (If not institution, give	MARTI	2		lb. City. Town. or	Location of Death	4c. County		1-100		
Examiner	GOODSAMARI		2		BALTIMO	re cin	1 Bout	MORECLI	M		
Funeral Director	213-24-4300	7. Age (In yrs. 73	last birthday) If Ur Yrs. Mont	nder 1 Year ths Days	If Under 24 Hrs Hours Min.	8. Date of Bird Month, Da APR • 2	7.0° 1926	9. Birthplace (Sta Country)	te or Forei		
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72 hours after death with the Maryland natural; or thems 23s or 28s-f show sites Examinat must be notified at sted by Funeral Director	MD. N/A	1	BALTIMOR	EΕ				17/21	res 201		
	10e. Street end Number 424 HORNEL ST.		10g. Citizen of V USA	Vhat Country?							
ral, or items 23. Exercises must	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:		ecedent of H specify Cuba is 2 TyNo		Specify Yes or No to Rican, etc.)		14. Race - American Indien, Black, White, etc. Specify: WHITE			
oted	15. Decedent's Ed (Specify only highest gra		16a. Decedent's t	Usual Occup f work done	ation during most of wo	rking	16b. Kind of Bu	siness/Industry			
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4-1	30. Name and address of person who a	completed cause of death (Item	ARTTAN ITO	0.00	2601 FOC	H REVEN	Societ A	226			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 9 40 Certificate of Death 2. Dete of Death 3 Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** December 21 orey /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 405 ore Ba NA ff Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number Funeral Days Months 1□M 2□F Yrs. 212-96-2708 ector 12 - 28 - 77Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f so... MD NA Baltimore X1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2811 Jefferson Street 21205 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. illed within 72 hours effer 1 Never Merried 2 Married 1 Yes 2 No 21215-0020 "netural", or þ 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced el Hygiene. d other than *netural event, the Medical F Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) White & Turner Elementery/Secondary (0-12) College (1-4or 5+) GED NA Construction Contruction Co, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Peges 1 and 2 should be filk ment of Health end Mentel Hy ant: If Item 27 is marked oth McCray, Wanda Ernest Drumgoole 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Wanda Drumgoole 2811 Jefferson Street Baltimore, MD. 21205 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Department of the post of the Maurial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Mem. Pk. Cem. 12-27-99 Arbutus, MD 21. Signeture of Euneral Service Licensee 22. Neme end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feiture. List only one cause on each line. Approximate Intervet Between Onset end Deeth **Physician** Immediate Ceuse (Finel /Medical diseese or condition resulting in deeth) Examiner Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to 24e. Wes en autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) To Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27 Menner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred edical Certification: After or Attending 1 Neturet 5 Pending investigation 24 hours after deeth. 1 Yes 2 No 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Ptece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 4 I Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. To the Hosp within 24 hor To the Fune completely fi 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier

State Registrar 31. Date filed (Month, Dey, Year)

DHMH 16 Rev 6/95

30. Name end address of person who completed, cause of death (Item 23a) (Type, Print)

DEC 3 0 1999

Illams

32. Registrar's Signature

Deperon

2401 W. Belvedere Bultone

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth Ac. County of Death Month 9 **Physician** Q VIRGINIA MATHENIA December 2 /Medical 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 XF Yrs Director 215-30-5107 July 7,1933 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantiner must be notified at some 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ▼ No Maryland Woodstock Directo 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 10302 Davis Avenue 21163 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Marifal Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Woodstock Elementary/Secondary (0-12) College (1-4or 5+) 12th. Postal Clerk Postal Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Edward Joseph Dennis Martha Rose Brantley 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Vernon Mathena, Sr. 10302 Davis Avenue Woodstock, MD 21163 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Lake View Memorial Park Jan. 3, 2000 Sykesville, MD 22. Name end Address of Fecility 21. Signatura of Funeral Service Licenses Loring Byers Funeral Directors, INC 8728 Liberty Rd.Randallstown,MD 21133-4784 23a Par (Enter the disease of complice from the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, but he, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediete Ceuse (Finel disease or condition resulting in death) . RESPIRATORY FAILURE SECONDARY TO /Medical Examiner Due to (or el e consequence of): KEFRACTORY Examir physician and is the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MODULAR SCLEROSING Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical **28 880** Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by detacl 1 | Yes 2 | No 3 | Probably 4 MUnknown signed d be det þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1□ Yes 2No 2 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 報 27. Manner of Deat 28e. Dete of fnjury (Month, Dey Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification: Atter Attending 5 ☐ Pending investigation Natural death. 1 Yes 2 No 2 Accident after deat Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 4 Homicide ATO The Hospital o within 24 hours at To the Funeral Di gongistely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end pleca, end due to the ceuse(s) end menner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of pertiller 29c. License number m.D Doo 41410. December 30th under 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lo GIN DER P MEHTA

CENTER RANDAUSTUWN MD

State Registrar MORTHWEST

DEC 3 0 1999

31. Dete filed (Month, Dey, Year)

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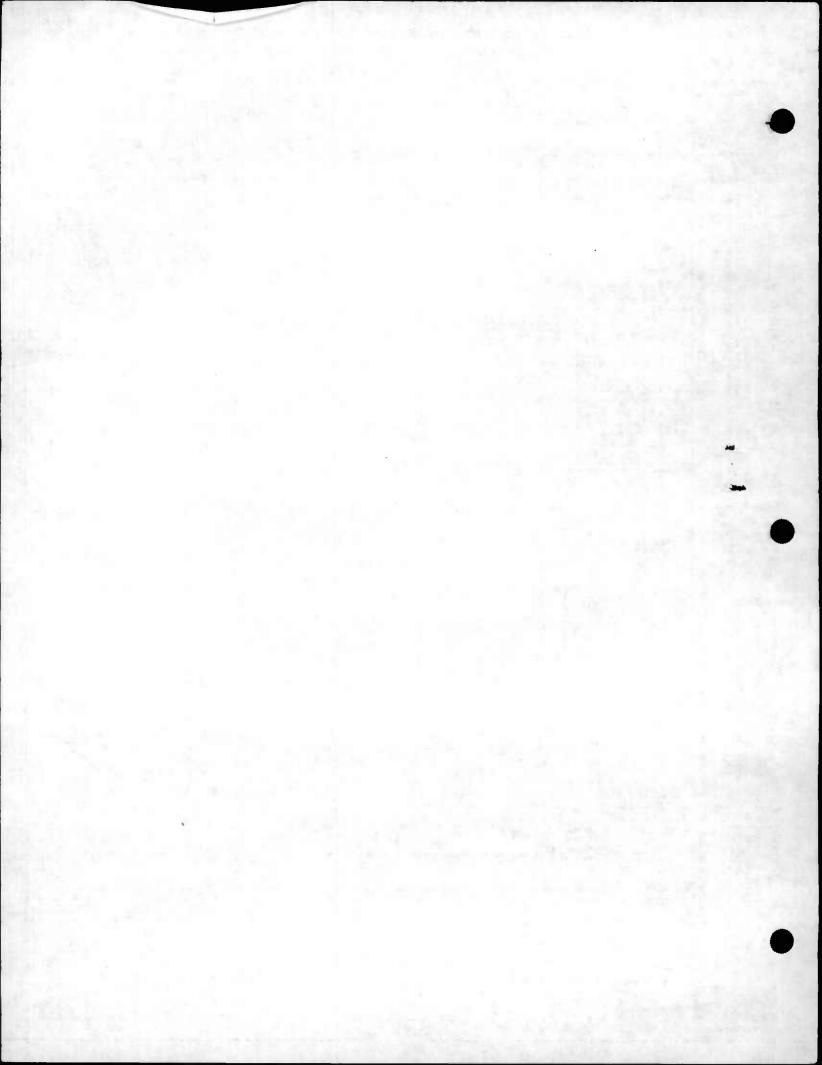
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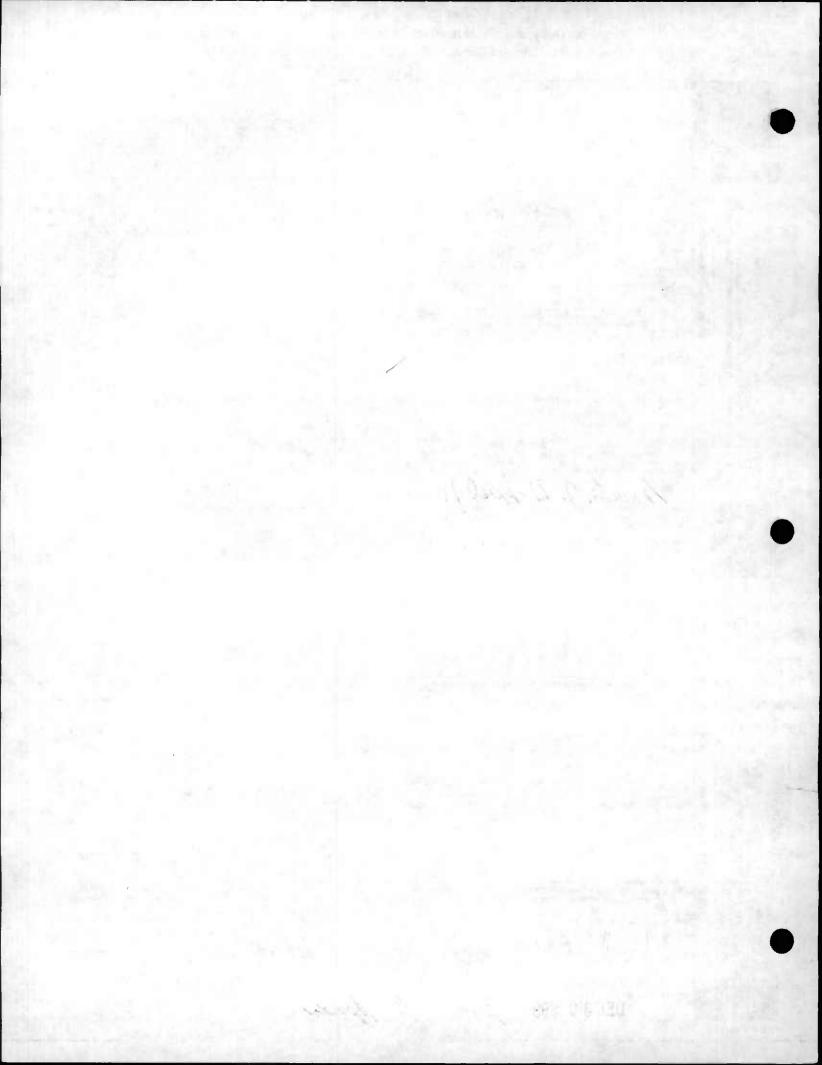
Box 68760 P.O. Records, of Vitai Division

O.C.M.E. DECEMBER 24, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) es tane (111 Penn Street, Baltimore, Maryland 21201 05 31. Deta filed (Month Dey, Year) 32. Registrar's Signature 3



State of Maryland / Department of Health and Mental Hygiene

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	Physician /Medical	1. Decedent'a Name (2. Data of De Month DECEMB	Dey	Yaar 1999	3. Time of Death 12:58 PM.		
7	Examiner	4a Facility Name (If no UNION		4	b. City, Tov BALT		cation of Deat	h 4c. Count	y of Deeth							
	Funeral Director	5. Social Security Num 286-05-8							ar If Under 24 Hrs. 8. Date of E			th 1916	plece (State or Foreign http:) yland			
Meryland	a show	Usuel Residence of Do 10a. State 1 MD	ocedent 0b. County N/A		10c. City, Town or Location Baltimore									10d. Inside City Limits Yes 2 □ No		
ith the N	23s or 28s-f show unit be notified at rai Director	10e. Street and Numb					10f. Zip 6							What Country?		
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	T is me traum	19a Informent's Name Mr. Yale								te 6	000 Bal	er, City or Town timore,	n, State, Zip mary	1201 (Code)		
ore	720	20e. Method of Dispos 1 ☐ Buriel 2 ☐ 4 ☐ Donation 5	Cremation 3 [Removal from	emoval from State 20b. Place of Disposition (Name of cametery, cremetory or other p. Balto/Wash. Crem.					matory 12/30/99 Laurel, Mary						
Balt Permit.	Depertment of Important: If any Injury or once.	21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Dippel Funeral Home 7110 Belair Road Baltimore, Marylan												nc. 21206		
E:	Medical kaminer	23a. Part 1. Enter the shock, or heart for hea			eriosc	lerotic	Cardi							Approximata Interval Between Onset and Death		
ox 68760,	nding physician end use as the bunal-trensit n/Medical Examiner	Couse (Disease or Injury that initiated events resulting in death) Lest Dua to (or as e consequence of): d														
Beath	for for												ontributa t	buta to the cause of death?		
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Ital R	certificate he rector, page	25. Was çase referred	I to medical						26. Place	of Deeti	1 Check only	Yes 2 No	11	Yes 2 No		
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Division or Attending	ector: After by the fune lification	1 XNatural 2 Accident	5 Pending investigetion 6 Could not be determined	e 28e. Plec	of Injury nth, Dey Year) e of Injury - At ling, etc. (Spe	M 1 ☐ Yes 2 ☐ No					28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					
Hospital or	in 24 hours aft he Funerel Di pletely filled in edical Cer	29a. Certifier 11 (Check only 2	Certifying Ph	yelclan: To the	e best of my ki	nowledge, deat	h occurred e	et the tin	ne, date en	d place,	and due to the	cause(s) and n	nenner as s	iteted. o the cause(s)		
Tothe	To the complete	29b. Signature and titl		and mer	nner stated.	1.1		. Licens	e number			29d. Date sign	ad (Month,	Day, Year)		
(N	30. Nama and audress JOSEPH	PESTANEI	R M.D.		111 Pe		reet	, Bal	timo	re, Ma	ryland 2	21201			
	State	31. Det Month,	Day, Year)	32.1	Registrer's Sig	nature	1		,							



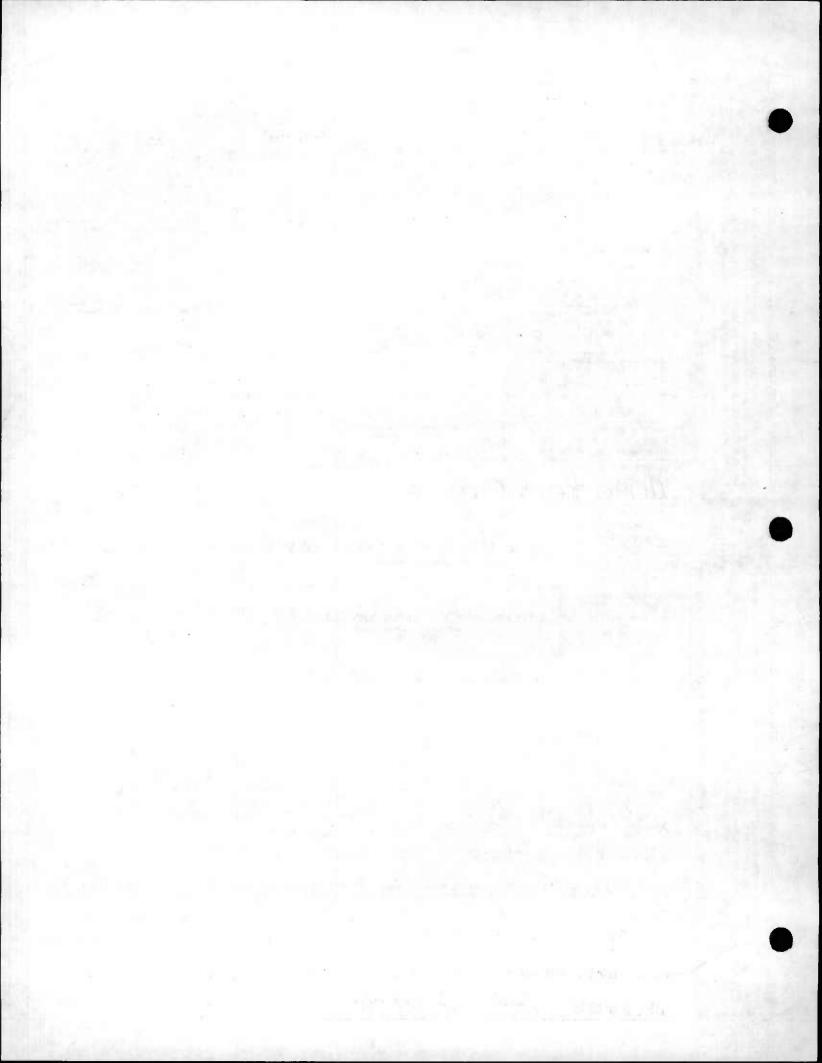
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State of Maryland / Department of Health and Mental Hygiene

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DEC 3 0 1999

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** ALP MURD DECEMBER 25,188 1120 PM tion of Death | 4c. County of Deeth /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner GENESIS ELDERCARE RANDALLSTOWN BALTIMORE M Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** M 2□F Months Yrs. Director 68 217-24-0855 1 - 20 - 31MD Usuel Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □ No 2 □ No Directo BALTIMORE n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 234 1019 MT. HOLLY ST. 21229 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? fix Yes 2 □ No fixes, Give Yeer or Detes: 1 Never Merried 2 Married 8 1 Yes 2 No 3altimore, Maryland 21215-0020 Specify: Specify: BLACK py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) -12--4-CLAIMS EXAMINER SOCIAL SECURITY 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be 10 ment of Health and Mental H lant: If Nem 27 is marked oth Be LOUIS B. MURDOCK, SR. MARY DRUMMOND 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Hea BARBARA MURDOCK (WIFE) 1019 MT. HOLLY ST. BALTIMORE, MARYLAND 21229 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Department of Important: If Is any injury or o 1 Burial 2 Gemetion 3 Removel from Stete 4 Donetion 5 Other (Specify) BALTIMORE NATIONAL 12-30-99 BALTIMORE, MARYLAND of Funerel Service Licenses 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Farth. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and k, or heer failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical · PROBABLE UROSERSIS Examiner Physician/Medical Examiner DEAYDRATION for use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of) The law requires that the death certificate be execu Box 68760. Due to (or es a consequenca of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thknown CEREBROVASCULAR ACEIDENT, HISTORY Records, 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy Be Completed OF DEED VEIN THROMBOSCS OF LGG 1 Yes 2 No 1 Yes 2€ No of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Division 1. Netural 5 Pending investigation death. 1 Yes 2 No e Hospital or Attending 24 hours after death Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as steted. edicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number

State Registrar

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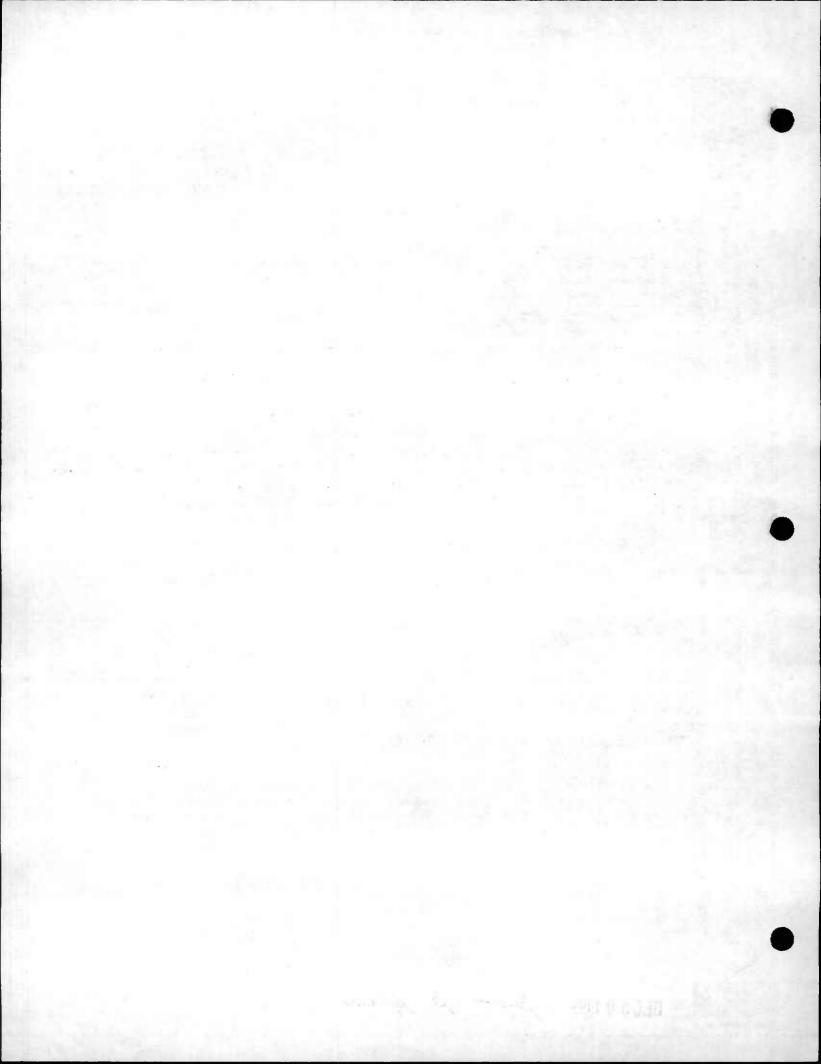
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ATTENSING

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

P. D. DESAL, JULY 23 CROSS ROADS
31. Dete filed (Month, Dely, Year)
32. Registrer's Signeture

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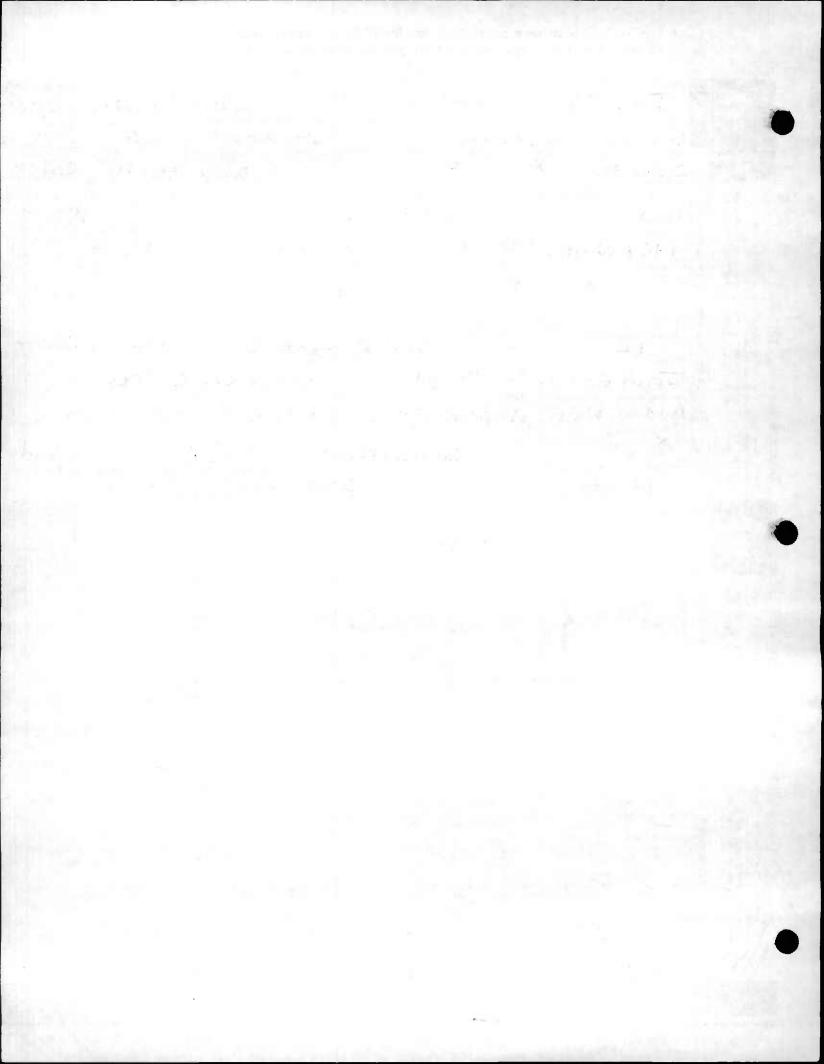
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Nastvogel Month **Physician** nomas DECEMABL 10:06 A.M. /Medical 4a. Facility Neme (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deeth Examiner BAKTIMOKE GOED SAMAKITAN HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Months Days 10XM 20 F Hours 216-01-383 Director December 28, 1917 Maryland Usual Residence of Decedent 10e. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Medical Examinar must be notified at 10d. Inside City Limits Baltimore MD 1 X Yes 2 □ No Director 10e Street and Number 10f. Zlp Code 10g. Citizen of What Country? 1907 Winford Road 2123 U.S. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 120 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or then any injury or other traumatic svent. the Mentel Item Con Black, White, etc. 1 ☐ Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: P Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Marking Device Sales Represenative 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Nastvogel John Edwin Genevieve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Andrey Nastrogel-Spouse 1907 Winford Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete Buriat 2 ☐ Cremation 3 ☐ Removal from State Dec. 30) 4 □ Donation 5 □ Other (Specify) Garrison, Maryland Garrison Forest 1999 22. Name and Address of Facility Evans Chapel of memores
8800 Harford Roge 21234 21. Signature of Funeral Service Licenses 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Final disease or condition resulting in death) Asthma Examiner Due to (or as e consequence of): Examiner o somuchine physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical attanding I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown Records, þ Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? paga 2 certificata 1 Tyes 1 Yes 2 No Division of Vital or Attending Physicien: The after death.
In Director: After this certificated in by the funeral director, pe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) MI) D31414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Strair A. Hastmi & 21 N Enlaw 87 Smt 308, Bult-mp 21201

State Registrar 31. Date filed (Month, Day, Yeer)

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32. Registrer's Signature

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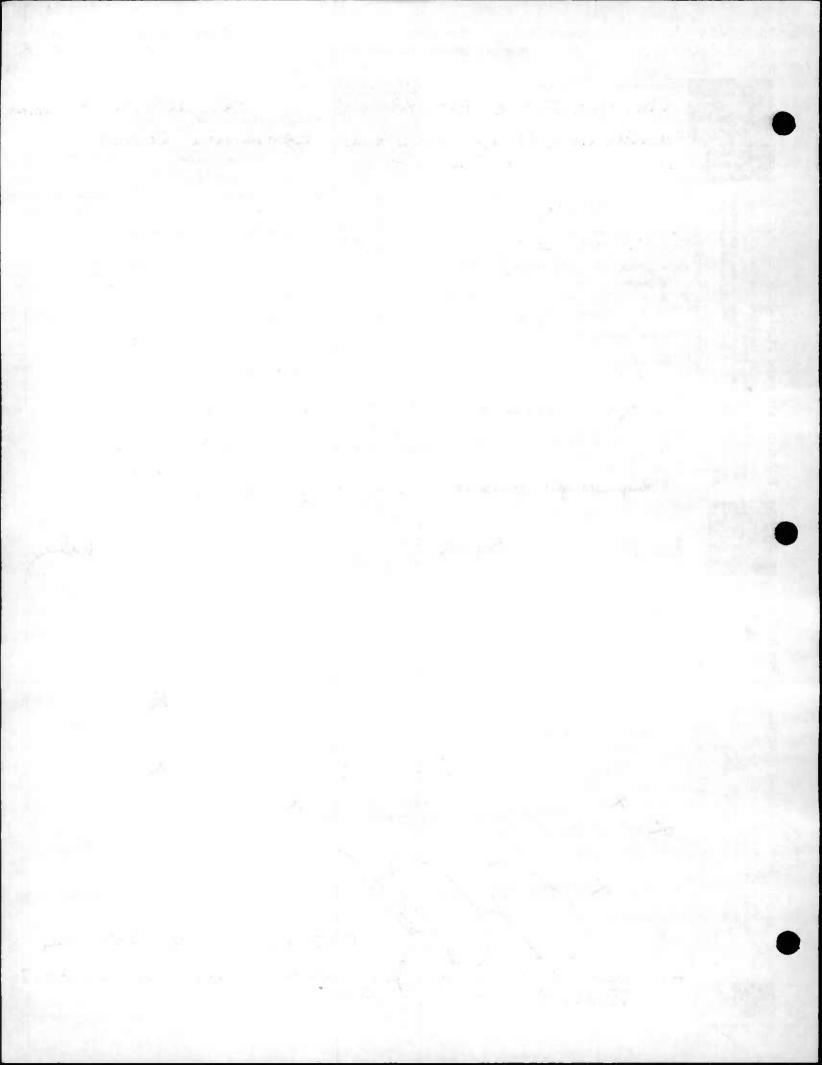
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2 Date of Death Month **Physician** Christine Inene Dec Neumann 28th 1994 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Carroll Lethern Village Sga (In yrs. lest birthday) If Under 1 Year Westminister Coursell 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign - Country) **Funeral** 216-20-4682 Hours 1 □ M 250 F 82 Director Feb 24 1917 Usual Residence of Decedent 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f shot other treumstic event, the Medical Examinar must be ricitized at Md Carroll Westminster Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 200 St. Luke's Circle 21158 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar In U,S. Armed Forces? 14. Rece - Amarican Indien. permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or itel eny injury or other treumetic event Bleck, Whita, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e, Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) homemaker domestic 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be Charles C. Becker Irene Jefferson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 Harvest Farm Rd., Sykesville, Md 21784 19a. Informent's Neme/Relationship (Type, Print) Charles E. Naumann Jr. (son) 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 ☐ Cremetion 3 ☐ Removel from State 1-3-00 Parkwood Cemetery Baltimore, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Haight Funeral Home & Chapel 21. Signature of Funerel Service Licenses Maige Haight Herbert P.O. Box 195, Sykesville, Md 21784 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical fmmediate Ceuse (Finel disease or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In death) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of deeth? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were eutopsy findings aveileble prior to Completed 24e. Wes en eutopsy performed? completion of causa of deeth? page 2 s 1 Yas 1 ☐ Yas 2 ☐ No certificate Division of Vital Attending Physician: director Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred After Natural Accident 5 Pending Investigation I or Attendin after death. Director: Aft d n by the fur 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, street, fectory, or ice building, etc. (Specify) 4 | Homicide To the Hospital

Within 24 hours a
To the Funeral C edicai Certifying Bhysician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and marker stated. 29a. Certifier fied et the time, dete end plece, end due to the ceuse(s) end manner es steted. etion, In my opinion, death occurred et the time, date end place, end due to the ceuse(s) 29b. Signeture end title of certifie 29d. Date signed (Month, Dey, Year) 29c. License number 30. Nema and eddress of pe n 23a) (T

32. Filipistrar's Stephen

weremula, My 21157

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 40936 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Yaar Month 27th 1999 REVA NEUHAUSER 03:30 DEC 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth BALTIMORE NIA LEVINDALE | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | OCT • 31 , 1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 10 M 20 F 91 216-16-0846 Yes MD Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits OWINGS MILLS BALTIMORE 10X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 SIERRA 21117 COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 XNo If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: WHTTE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOMEMAKER 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) RICHELSON LEVIN **ABRAHAM** SARAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) RANDALLSTOWN, MD STANLEY NEUHAUSER (SON) 8616 LUCERNE RD.

Physician /Medical Examiner

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Aftert

spital or Attanding Prous effer death.
nerel Director: After / filled in by the funer

To the Hospital of within 24 hours of To the Funeral Discompletely filled I

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

of Vital

Division

Physician

/Medical

Examiner

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MD

Director

Funeral

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Completed

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the Maryland

death

a filed within 72 hours after di Hygiena. other then "natural", or Item

other

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked other any Injury or other treumatic event bace.

Baltimore, Maryland 21215-0020

physician s the burial edicai ettanding s **Physician/M** pendis tep ed p à

25. Was casa referred to medical examiner? å 1 Yes 2 No Certification: To 27. Manner of Deeth 1 Natural 2 ☐ Accident

str Immedieta Cause (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed

5 Pending investigation

6 ☐ Could not be

cuesley

20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State

4 Donetion 5 □Other (Specify)

21. Signature of Funeral Service Licensee

SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat end Death CORONARY LOYRS ARTERY DISEASE Due to (or as a consequence of): 20415 SENILE DEMENTIA Due to (or as a consequence of): 10 415 DEPRESSION Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy

20b. Place of Disposition (Name of cemetary, cremetory or other place)

MIKRO KODESH-BETH ISRAEL 22. Name and Address of Facility

Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) DEC 3 0 1999

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

W. BELVEDER E AVENUE 32. Registrar's Signature

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Tima of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

m.D

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE oaks

28c. Injury at Work?

1th Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number

1 | Yas 2 | No

D 0054739

MARYLAND

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

21215

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

DECEMBER 27th 1999

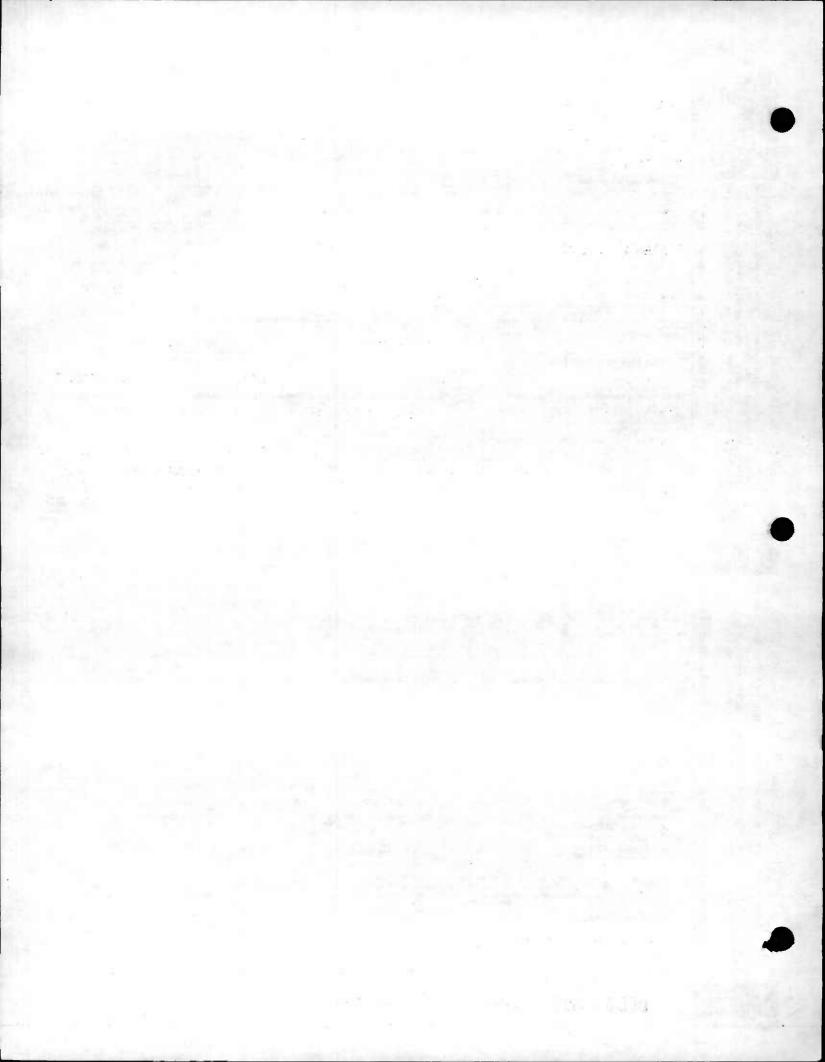
20c. Location - City or Town, Stata

BALTIMORE, MD

1 ☐ Yes 2 No

Date

12/29/99

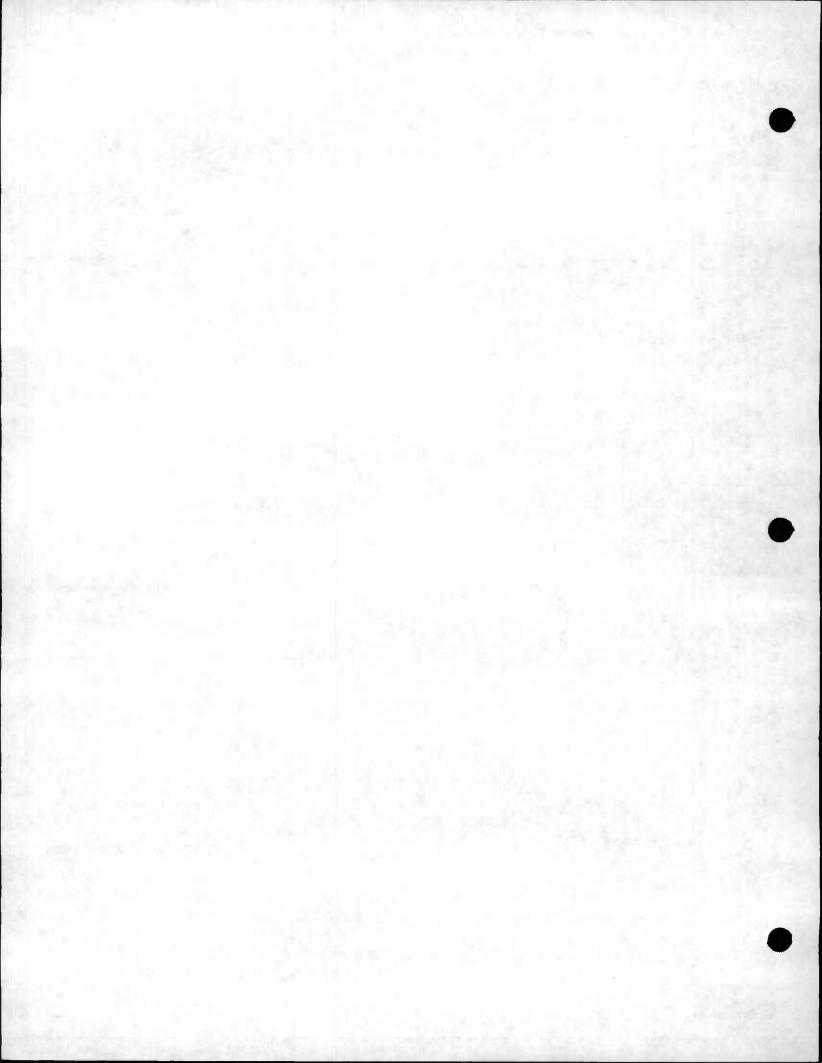


State Registrar **DHMH 16 Rev 6/95**

ORIGINAL

32. Registrar's Signatura

DEC 3 0 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Deeth 3. Time of Death Gilberto Persichitti Sr. 25. 1999 0946 AM DECEMBER 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 6. Sex Birthplece (State or Foreign Country) Months Days Hours 1⊠M 2□ F Yrs. 212-42-2236 60 Italy 2 -1939Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits MD Elkridge 1 ☐ Yes 2 XNa Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5847 Blue Sky 21075 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Merried White If Yes, Giva Yeer or Dates: 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Tailor Hartmax Corp. 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Gaetano Persichitti Anna Coladonato 19e. informent's Name/Reletionship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Josephine Persichitti 5847 Blue Sky, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 12/29/99 Baltimore, Co. Maryland Dulaney Valley 4 □ Donetion 5 ☑ Other (Specify) entomb. 22. Name and Addrass of Facility Joseph N. Zannino Jr. Funeral Home 21. Signeture of Funaral Service Licenses 263 S. Conkling Street, Baltimore, Maryland 21224 mneno syste Approximate Intervel Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, nock, or heart tellure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MONTHS LIVER METASTASES AND MALIGNANT ASCITES Due to (or es e consequence of): UNKNOWN PRIMARY CANCER MONTHS Sequentielly tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): that initieted events resulting in death) Last Due to (or as a consequence of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

sician and burial-transit

attending physician for use as the burie

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peeu page 2 certificate

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Ne Hospital or Attending n 24 hours efter death. Ne Funeral Director: After pietely filled in by the fun

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The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Mi Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28s-4 is eny injury or other treumatic event, tra Medical Examinat must be nothing.

21215-0020

Baltimore, Maryland

Physician/Medical Examiner Àq Completed 8

25.	Wes case referred to medical		26. Place of Deeth (Check only one)							
	examinar?	No	Hospitel: 1 Inpatient 2	3 DO	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)				
7.	Menne of Death 1 Whatural 2 Accident	5 Pending investigation	28a. Dete of injury (Month, Day Year)	28b. Time of tnjury	M 28	lc. tnjury at Work? 1 Yes 2 No	28d. Describe how Injury occurred			
	3 Suicide 4 Homicida	6 Could not be detarmined	28e. Place of Injury - Ath building, atc. (Speci	nome, term, stree	t, factory,	28f. Location (Street and Number or Rural Route Numb City or Town, Stata)				

29b. Signeture and title of Cono

29c. License number

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29d. Dete şigned (Morth, Day, Year)

30. Nama end addrass of person who completed cause of death (ttern 23a) (Type, Print)

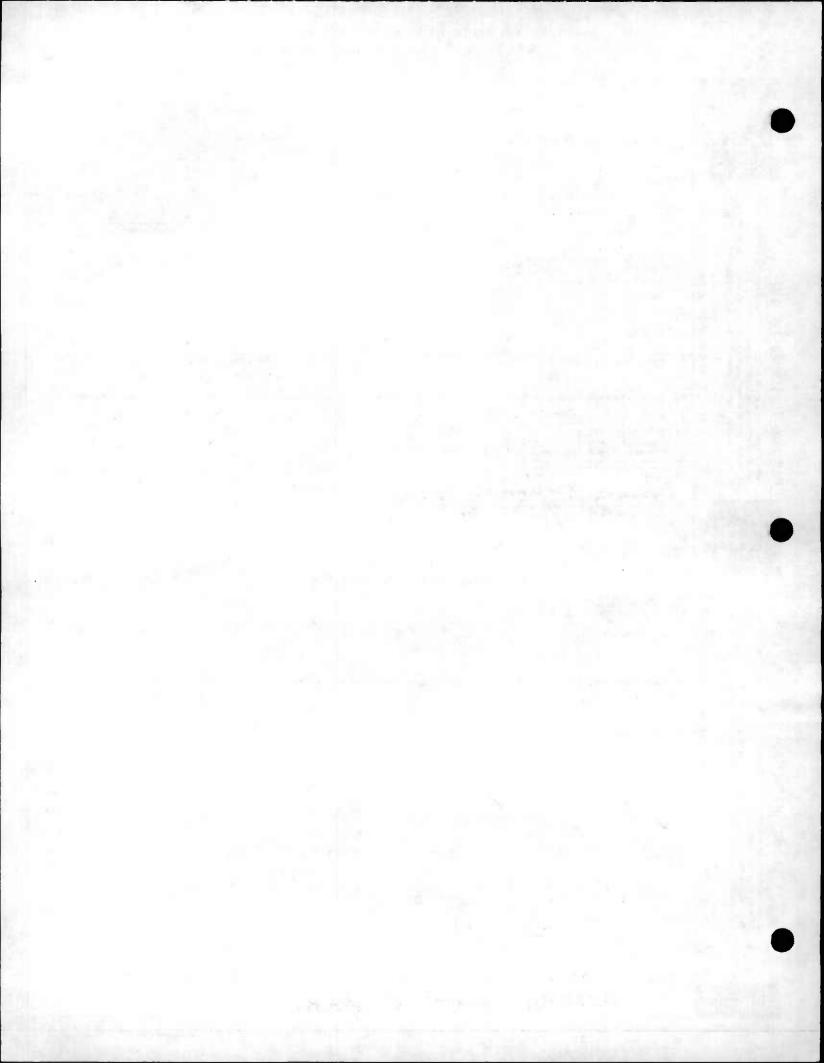
7601 OSLER DRIVE, TOWSON, MARYLAND 21204 TIMOTHY LOW, M.D., 31. Date filed (Month

State Registrar

Medical Certification: To

32. Registrer's Signeture 1999

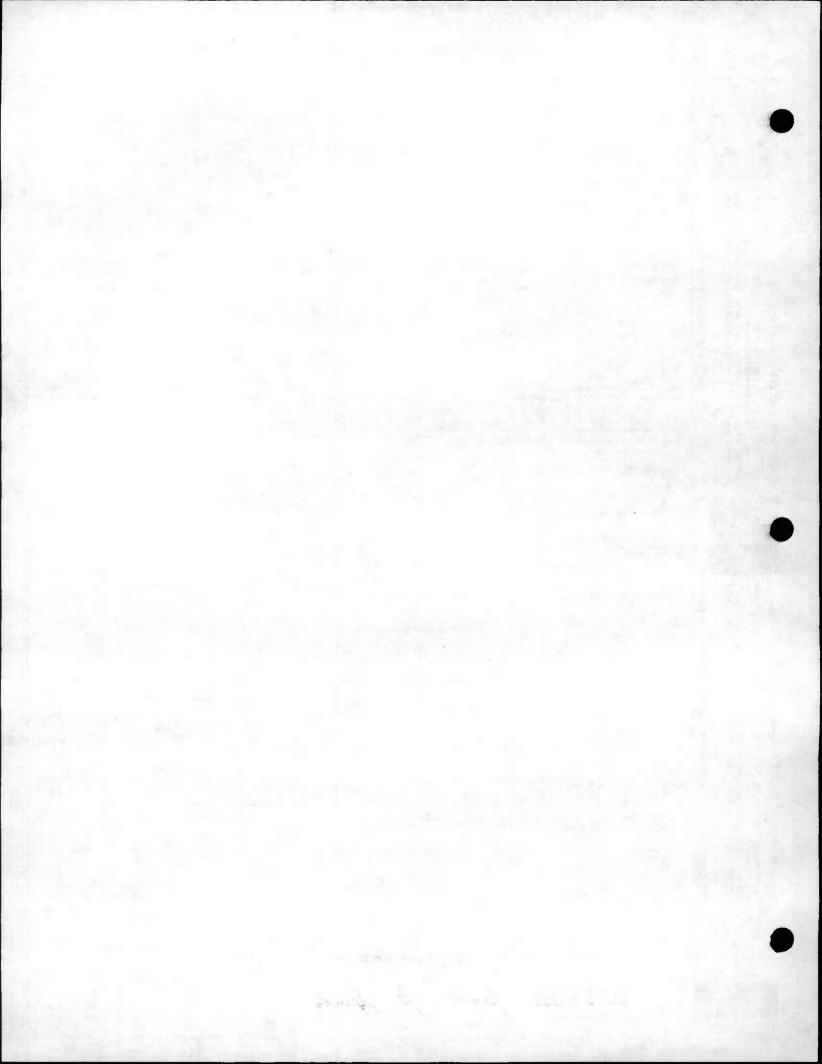
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER /Medical 4b. City, Town, or Location of Death ty Name (If not Institution, give street and number) 4c. County of Death Examiner N/A If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** unknown 1□M 2MF Yrs. Director 69 unknown Jan 1, Usual Rasidance of Decedant death with the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at unknown unknown unknown ↑ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 USA unknown unknown 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No or Nema Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: white Yas. Giva Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien important: if item 27 is marked other the any holury or other traumatic event, the page. unknown unknown unknown unknown Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) **JHBMC** 4940 Eastern Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stafa Mathod of Disposition
1 □ Burial 2 □ Cramation 3 □ Ramoval from State 4 Donation 5 Dother (Specify) 21 Signature of Reports Service Scioerene Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 art1. Enter the diseas plication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediata Cause (Finel disaasa or condition rasulting in death) /Medical Examiner Due to (or es a conse Physiclan/Medical Examiner Attending Physician: The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diseese or injury that initiated evants resulting in death) Last Dua to (or as e con P.O. Box 68760, Due to (or as a consequence of): USB BS Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? should be detach 1 Yes 2 No 3 Probably N⊠Unknown Division of Vital Records. p Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yas 20 No 1 Yes 2) No certificate funeral director. Be 25. Was casa refarred to medical exeminar? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Deta of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After To the Hospital or Attenuing within 24 hours after death.
To the Funeral Director: After To the funeral Director: After To the funeral Director of the Netural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Place of fnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifian (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Weiss Resident Physiochn 30. Name and address of person who complated cause/of death (Item 23a) (Type/Print) 32. Registrar's Signature 31. Data filed (Ma State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Dec. 28, Day 1999 **Physician** 1:45 p.m. Louisa M. Pfister /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore 144 Chestnut Hill Rd. Reisterstown 5. Social Security Number 212-32-1001 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23, 1935

8. Birthplace (Stete or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 XF Deys Hours Min 64 Yrs. Director Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Reisterstown Director Md. Baltimore than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number
144 Chestnut Hill Rd. 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21136 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②CNo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 (Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 12 permit. Pages 1 and 2 should be flist
Department of Health and Mental Hy
Important: If flem 27 is marked othe
any injury or other treumetic event 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Thelma Hoffman Sylvan Aaron Manger 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10 Staley Court, Reisterstown, Md. 21136 Lisa Schmidt - Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Mt. Olive Cemetery Dec. 31, 1999 Randallstown, Md. 4 Donation 5 □ Other (Specify) 22. Name and Address of Fecility

Eckhardt Funeral Chapel 21. Signature of Fungral 4 envice License 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deat Physician Immediele Cause (Final disease or condition resulting in death) /Medical (Adenvea unome) 6.mostb. CAMUR Examiner Dono (or es e consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by Bane metestasis, jothologic facitures. 1 Yes 2 No 3 Probably 4 Unknown Records. 24b. Were eutopsy findings eveilable prior to 24e. Wes an autopsy performed? Completed Osesity Disseter Messitar Antivid completion of cause of death? or death? NA 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 1 ☐ Yes 2 No Division of Vital 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) this 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury et Work? ne Hospital or Attending P n 24 hours after deeth. The Funeral Director: After the pletch filled in by the funeral Work? LA 1 Yes 2 No After 5 Pending investigation 2 Accident NAI NA 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide WITI 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14811 hoper MD 12-29-99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADOLFO L LOPEZ 8415 RELLOINH LANE TOWSON. MA 21204 31. Dale filed (Month, Day, Year) 32. Registrar's Signeture DEC 3 0 1999 Registrar

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1165 Sciebeller Land., Colored 111, co. 2117

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth HOWARD ROBERSON 330 28 Dec 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Good Samaritan thes Age (In yrs. last birthday) If Under 1 Year Months Deys BALTIMORE BALT IMUKE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) Deys 1. M 2□ F 237-52-0902 NC Usuel Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore NO 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2811 Goodwood Avenue 21214 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2020No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) NA Welder Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Augustus Roberson Alice Slade 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21214 19e. Informent's Name/Reletionship (Type, Print) Gloria 2811 Goodnow Avenue Baltimore, Maryland Roberson 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XX Buriel 2 Cremetion 3 Removal rom Arbutus Mem. Pk. Cem.01-02-2000 Arbutus, 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral Service L 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, an on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final Imonary disease or condition resulting in death) Imme dut Due to (or as e cons Due to (or es e consequenca ol): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 22 No 3 Probably 4 Unknown

Physician Examiner

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To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

by

Completed

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Certification:

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

requires that the death certificate be execu P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

10e. Stete

Director

Funeral

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Completed

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Funeral

Director

with the Maryland

is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mant be notified at

Department of Health and Mental Hy, I have a more than 18 merkad other my or other traumatic average.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In death) Lest Physician/Medical

25. Wes case referred to medical examiner? Hospital: 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Naturel 5 Pending investigation 2 Accident

6 Could not be

24b. Were eutopsy lindings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Tes 2□No 1 Yes 2 No

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, lactory, offica building, etc. (Specify)

Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

. Signeture end title of cartifier 29c. License number

tampatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

29d. Date signed (Month, Dey, Yeer)

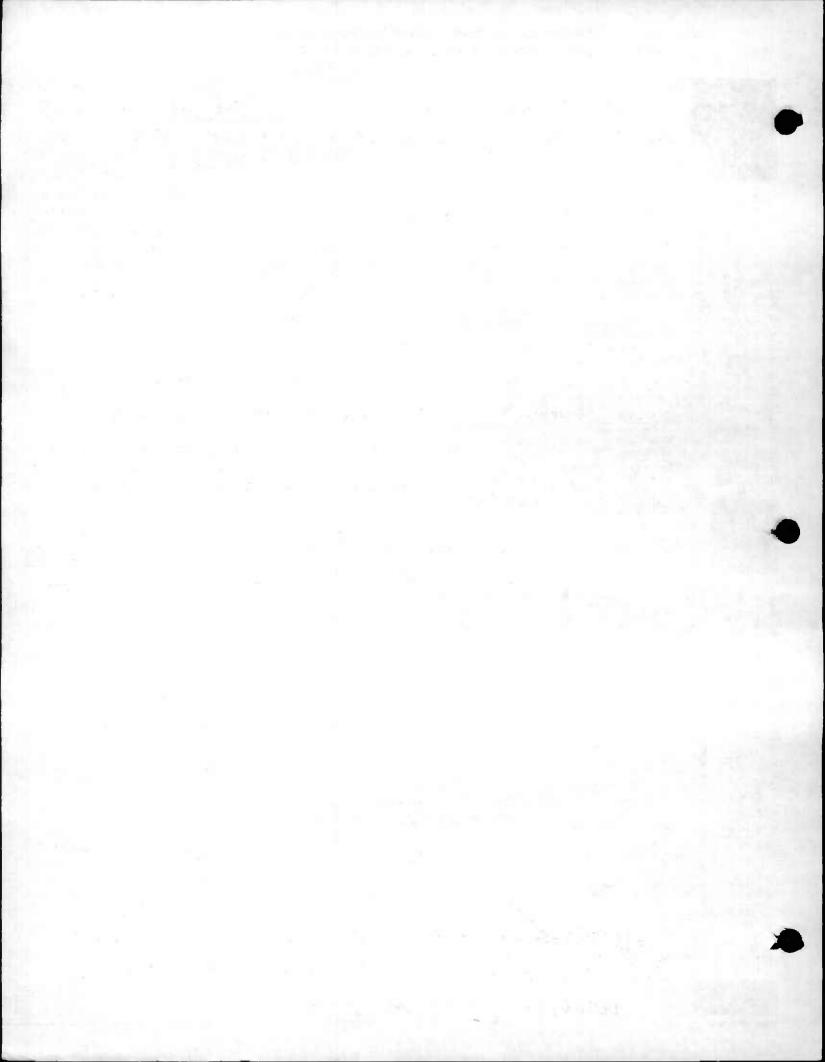
30. Name end doress of person who completed cause of death (Item 23a) (Type, Print)

ACLING FFREY

31. Dete liled (Month, Dey, Year) 32. Registrer's Signature Geneva DEC 3 0 1999

Good Someton Hospe, Boltimore, MD

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Yaar Physician SHIRLEY REED 30' 1999 December /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ct 184 Himore 4asprine H Undar 1 Yaar | H Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months 112M 20 F Yrs. 231-14-1273 Director 76 AUG 6 1923 VIRGINIA Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show na 23a or 28a-f show XXYas 2□No Director MARYLAND BALTIMORE CITY N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 MOUNT HOLLY AVENUE 21216 U.S.A. Funeral Rem 27 is marked other than "natural", or Rema other traumatic event, the Medical Examinal management. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐XŊŎ If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. a filed within 72 hours after de li Hygiene.
other than "natural", or item Black, Whita, atc. 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yas 2 ☐X No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) BETH STEEL TRACTOR OPERATOR 12th grade Pages 1 and 2 should be filed nant of Haalth end Mental Hygi ant: If item 27 is marked other 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) ELIJAH REED MARY BAILEY 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Elma Reed/Wife 2909 Mount Holly Avenue, Baltimore Maryland 21216 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Department of H Important: If its any injury or ot once. 1 Xurial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) REED CEMETERY 1-5-99 SUSSEX CO., VIRGINIA 21. Signatura of Funeral Service Licenses 22. Nama and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA rows 1206 W NORTH AVENUE 23a. Part1. Entar tha disaasa, or complications that causad the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death .Physician Immediata Causa (Final disaesa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner DIALOIAL The law requires that the death certificata be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that Initiated avents rasulting In death) Last Dua to (or as a consequence of) the burial-tran Box 68760, Physician/Medicai Dua to (or as a consequence of): signed by the attending d be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has 2 No 1 ☐ Yas 2 🗷 No 1 Yes of Vital tal or Attanding Physician: The offer death.

It Director: After this certificated in by the funeral director, possible of the funeral director. Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Stinpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? 5 Panding invastigation Division 1 Natural 1 Yas 2 No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di complately filled in Certifying Physician: To tha best of my knowledga, death occurred at tha time, data and pleca, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and menner steted. 29a. Cartifiar (Check only one) 29b. Signatura and titla of cartifiar 29d. Date signed (Month, Day, Year) 29c. License number

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Registrar

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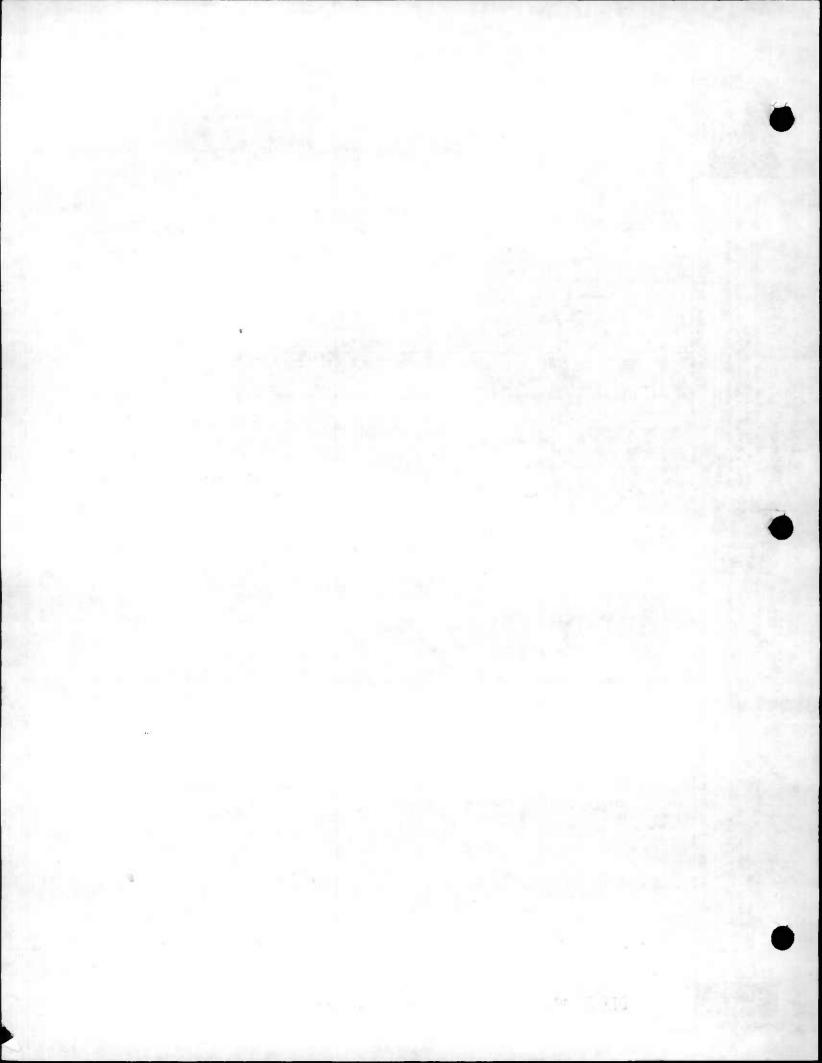
31. Data filad (Month, Day, Year)

30. Nema and addrass of person, who complated causa of death (Item 23a) (Type, Print)

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32. Registrar's Signatura

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			Certific	ate of	Death		Reg. No.	7.5	1940
Physician	Decedent's Neme (First, Middle, Lase Effie Eli:	zabeth Ros	ier			2. Dete of Dee Month Decemb	Dev	Yeer 999	3. Time of Deat 9:00pm
/Medical Examiner	4a Facility Neme (If not institution, give Continuum Care a	street end number) at Sykesville			4b. City, Town, o Sykesvil	Location of Deeth	4c. County		3.00pm
Funeral Director		9x □ M 2\XF 78	. last birthday) If Ur Yrs. Mont	hder 1 Year hs Deys	If Under 24 Hr Hours Mir		y, Yeer)	9. Birthpl Count Va.	ece (Stete or For
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	10e. Street end Number 136 Schoolhouse Ro	pad 101. Zip Code 21784				-	D. Citizen of Whet Country? USA		
	11. Maritel Stetus 1 □ Never Married 2\(\tilde{\lambda}\) Married 3 □ Widowed 4 □ Divorced	Armed Forces? If		Ves Decedent of Hispenic Origin? (Specify Y Yes, specify Cuben, Mexicen, Puerto Rican ☐ Yes 2♥ No Specify:					
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la by W	17. Fether's Neme (First, Middle, Last) Floyd Good			Name (First, Middle, Maiden Sumeme) M. Bradley					
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	20e. Method of Disposition 1X Burlel 2 Cremetion 3 4 Donetion 5 Other (Specify		1-3-00 S						
Department of important: If It any injury or one.	21. Signature of Funerel Service Licensee Page Haight Funeral Home & Cha P.O. Box 195 Sykesville, Md 21784								
	23a. Pert1. Enter the diseese, or comp shock, or heert failure. List only of	lications that caused the decone ceuse on each line.							Approximete Intervel Between Onset end Deet
nysician 'Medicai xaminer	Immediate Cause (Finel disease or condition resulting in deeth)	Dia	3 हर्ग्हर	ME	ZLITUS	N. C.			Yes
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loisn and burtal-transit al Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury	b. Due to (or es e consequence	of):	(n y				
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New	29b. Signature end title of certifier		29c. License number D 3 3 6 81			29d. Date signed (Month: Day, Year)			
1	30. Name end eddress of person who o	7)	om 23e) (Type, Print)	Way	B	DERSAL	all M	D	21784
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sign		/ /		7176	7100		, , ,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Amended Item#18 perFH G779 1/19/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Yee **Physician** Perry 7:45 pm 1999 Kichardson 26 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIT TITE JOHN.
5. Social Security Number HOSPITAL

7. Age (In yrs. last birthday) JOHNS HOPKINS If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Sex 1 ☑ M 2 ☐ F 20 125-74-383 Usual Residence of Decedent Vrs Director BERMULA the Meryland 10a. State 10b. County 10c. City, Town or Location in end Mental Hygiene. 7 ie merked other than "natural", or items 23a or 28a-1 ehow traumatic event, the Medical Examiner must be noutled at 10d. Inside City Limits 1 PYes 2 No BEEMULA St GEORGE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BERMUDA USA 3 LANE GEBX death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Status permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item page. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10915 +1CS INVENTOR 12 CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Irene Mechelle, Thomasar BRIAN OLIVER RICHARDSON 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEW COAS + LE, DEL

20c. Location - City or Town, State 46 VALLEY FORGE RA Chiff-YUAN ChEN

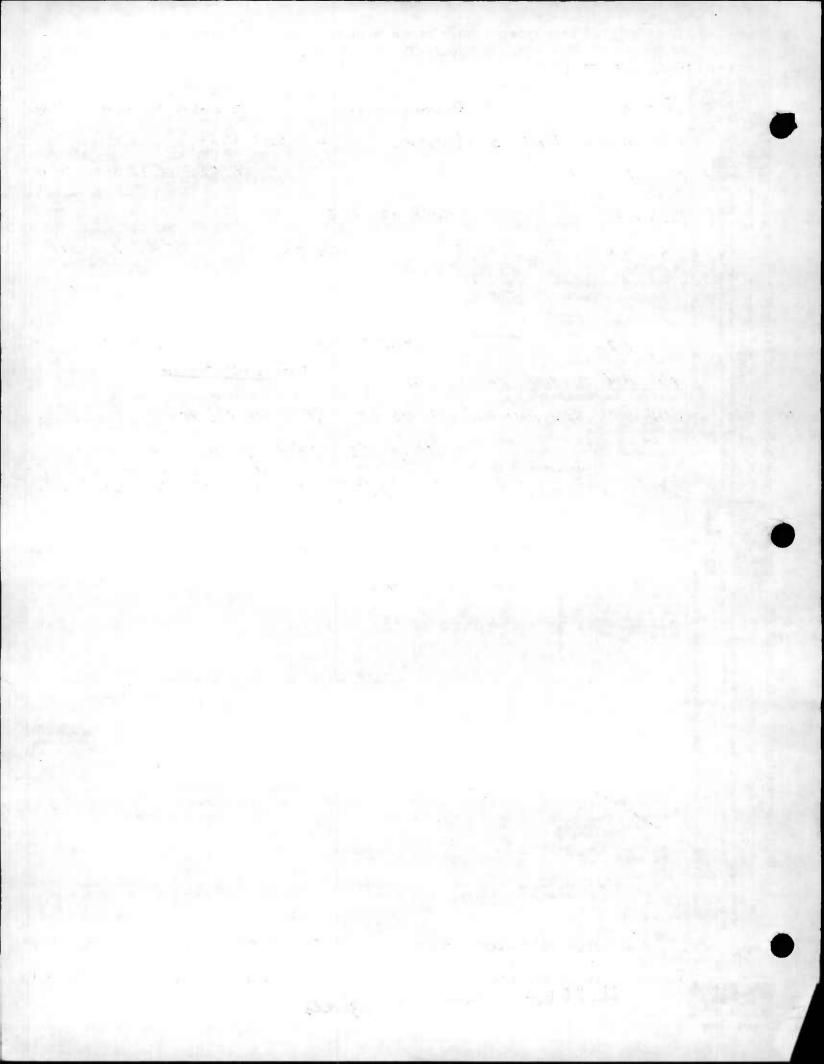
20a. Method of Disposition RichWoodSow 20b. Place of Disposition (Name of cometery, crematory or other place) 1 Surlal 2 Cremetion 3 Removal from State BERNUCK 1-5-2000 4 ☐ Donation 5 ☐ Other (Specify) TRINITY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HowELL FUNETCAL HOME 4600 LI BERTY HEISING AVE, BALTO, MU 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Krusei Sepsis Examiner one week Due to (or as a consequenca of): Physician/Medical Examiner Burkitts Due to (or as a consequence of): ettending physicien end for use es the bunel-transit we company certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760 that initiated events resulting in deeth) Last Due to (or es a consequence of): The law requires that the deeth P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Wes an autopsy performed' Il director, page 2 s 2 14 No 1 Yes 1 Yes 2 No Hospital or Attending Physician: 24 hours efter death. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Maturel Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner stated. Medical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-052133 Nuckes 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MD December 26, 1999

600 North Wolfe Street Bollman Maryland 21287

State Registrar Drucker

32. Registrar's Signature



99-7758-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, II, 27 PER Mentificate of Death Reg. No. " 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day DECEMBER 24, **Physician** RUSSELL ROBINSON, JR 99 1118 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland 502 W. Preston St. Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 43 yrs. 8. Date of Birth (Month, Day, Yes 1. 2 – 26 – 55 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours Min TOM 2DF Yrs. MARYLAND Director 213-62-5550 **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1 XYas 2 No Director 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 230 21040 2506 THORNBERRY DRIVE U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) natural, or hama 14. Raca - American Indian 11. Marital Status Black, White, atc filed within 72 hours after 1 Never Married 3 Married BLACK 1 Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th UNKNOWN UNKNOWN permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumetic event, app. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be ELLEN HIGGS RUSSELL ROBINSON, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2506 THORNBERRY DR, EDGEWOOD, MD 21040 RONDA S. ROBINSON, WIFE 20b. Place of Disposition (Nama of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 to Burial 2 ☐ Cremation 3 ☐ Removal from State MOUNT ZION 12-31-99 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility
HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE. BALTIMORE, MD 07 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death Physician Immediata Cause (Finat disease or condition resulting in death) /Medical CHRONIC NARCOTISM Examiner Due to for as a consequence of: Examiner The law requires that the death certificate be executed physician and the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? HYPERTENSIVE CARDIOVASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown signed b 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Yes 2 No 1 Yes 2 No certificate 8 25. Was case referred to medical director 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) SCENE NOYes 2□ No 2 this Certification 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of A hours after death.

An Director: After

'or by the IV Affer Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in 29a. Certifier (Check only one) In partition of the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. Medical Iner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signate 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar O

fonth, Day, Year)

30

1999

31. Date

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Saltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

completed cause of death (Item 23a) (Type, Print)

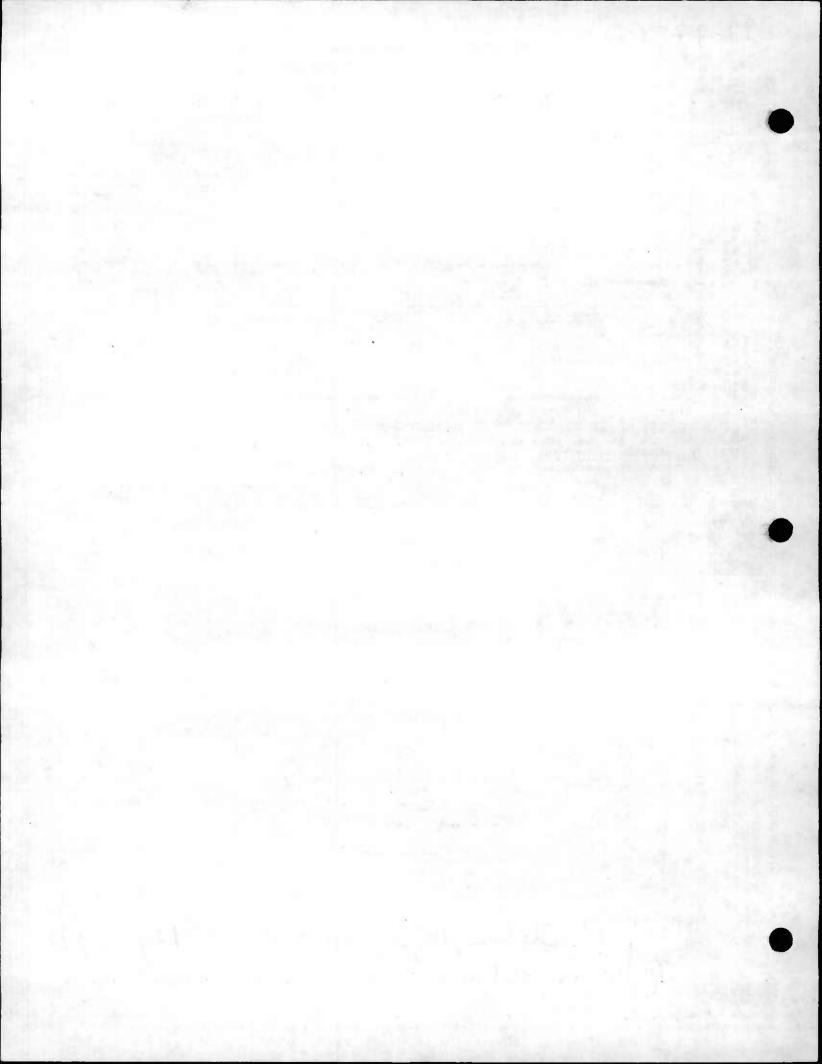
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32. Registrar's Signature

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O.C.M.E.

PENN STREET, BALTIMORE, MD 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month LINDA ROBINSON DECEMBER 22, 1999 1532 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth ST AGNES HEALTHCARE BALTIMORE N/A If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) Deys Hours Months 1□ M 2以 F Yrs 214-40-0228 9-20-40 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. N/A 1 X Yes 2 No BALTIMORE 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 1734 McKEAN AVE. 21217 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced BLACK Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) -12-NURSE HEALTHCARE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ROBERT TOOGOOD BLANCHE MARSHALL 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JAMES HARRIS SR. (COUSIN) 3834 SINCLAIR LANE BALTIMORE, MARYLAND 21213 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donetion 5 ☐Other (Specify) ENTOMBMENT ARBUTUS MEMORIAL PARK 12-28-99 BALTIMORE, MARYLAND 21. Signeture & Ed 22. Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. Hisner 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ralla Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, k, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Partf previoselevotic Cardiovascular Disease Immediate Ceuse (Finel disease or condition resulting in death) Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequenca of): thet initiated events resulting in deeth) Lest Due to (or es e consequence of) Part II. Other eignificent conditions contributing to cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Lona monic 1 Yes 2 No 3 Probably 4 Unknown ailune 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 Tyes 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 CPVOutpetient 3 ☐ DOA 27. Manner of Death 1 Naturel 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

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Medical Certification:

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and #ttle of certified

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at

"natural".

permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumetic event, the Me

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0020

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After t death. To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fi

Robinson

State Registrar

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year) December 23, 1999

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

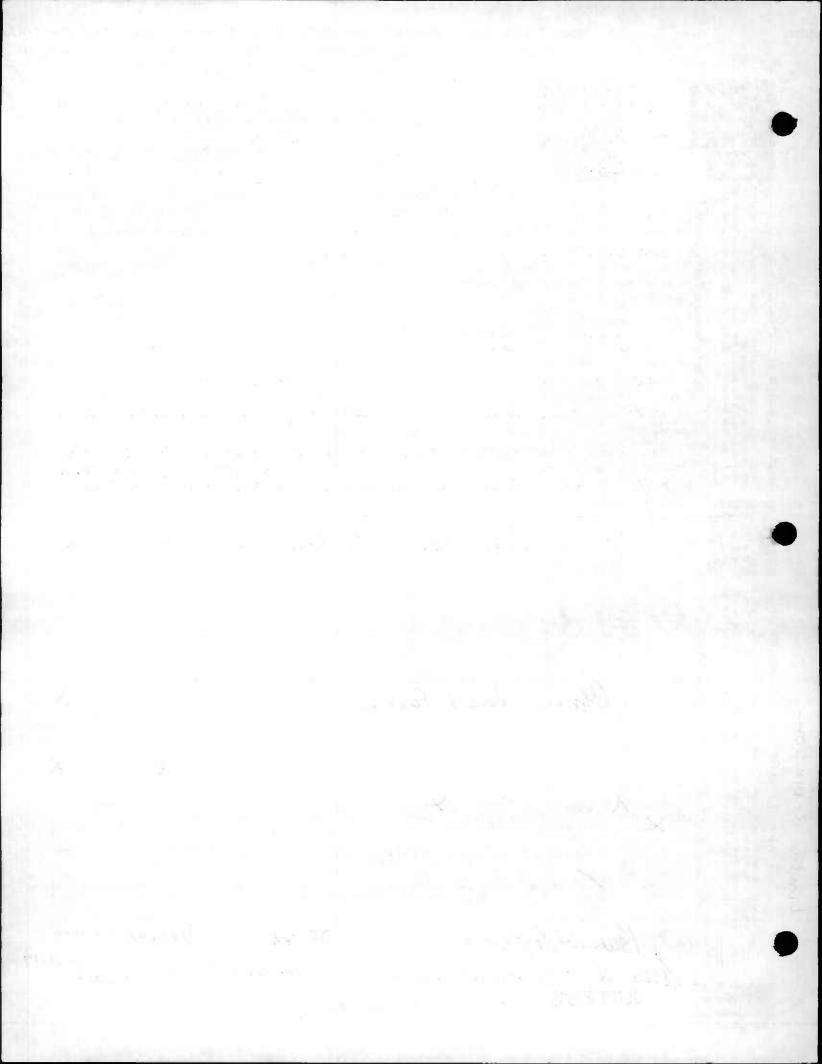
30 Name a d cause of deeth (Item 23e) (Type, Print)

6 Could not be determined

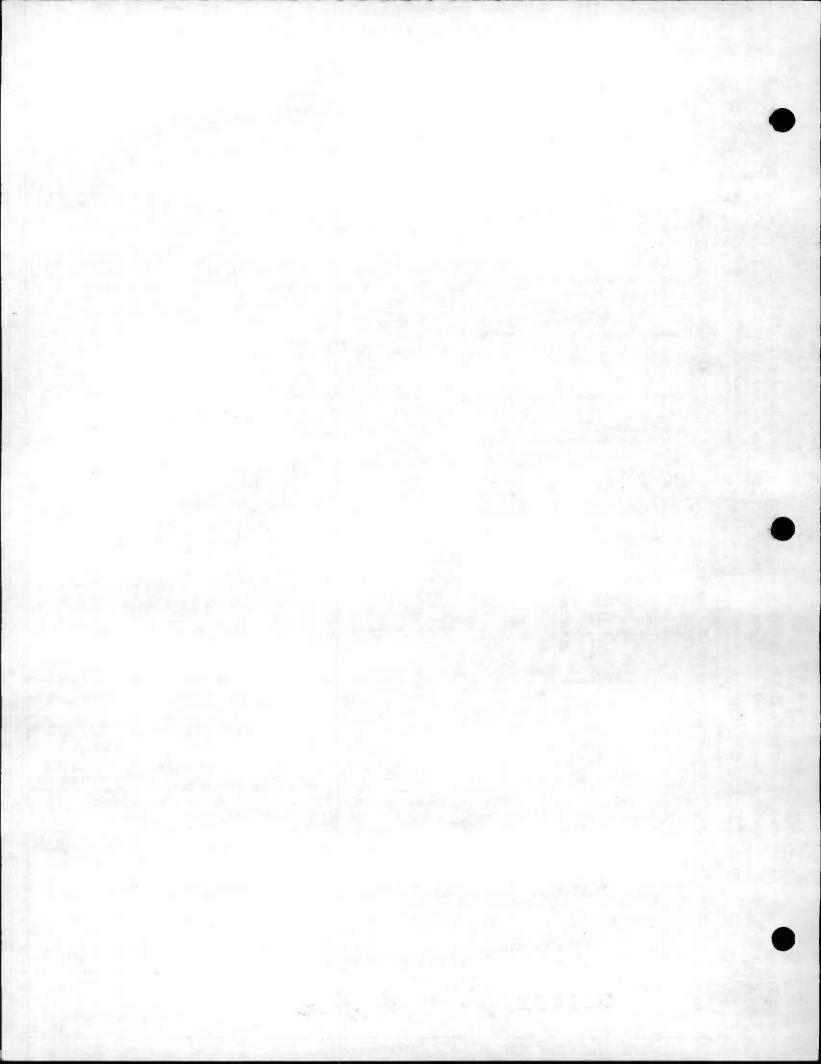
900 cator Armue Baltimor Marylan

37. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)



		- 43		Certifica	ile or D	- Outin		eg. No. ৺ ৺	1054
ian	1. Decedent's Neme (First, Middle, Las						2. Dete of Dea Month	Day	Yeer 3. Time of D
ical	Charles Frederick						DECEMB		1999 8:20
ner	4e Facility Neme (If not institution, give	a street end number)			4b	. City, Town, or I	Location of Deeth	4c. County	of Deeth
	GREATER BALTI	MORE MEDI	CAL	CENTER		TOWSO			TIMORE
	5. Social Security Number 6. Sa		(In yrs. last	birthday) If Und	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth	Year)	Birthplece (State or I Country)
	212-09-0599	XIM 2DF	91	Yrs.	Julys	THOUSE WITH	8. Dete of Birth (Month, Dey October 2	2,1908	Baltimore, M [
	Usuel Residence of Decedent								
	10e. Stete 10b. County		10c. City, To	own or Location					10d. Inside City
to	Maryland Baltimore Co. Towson								1 ☐ Yes 2
Directo	10e. Street and Number 10f. Zip Code							Og. Citizen of V	What Country?
	512 Locksley Road				2120	1		Inited St	ates of Americ
9	11. Marifal Status	12. Wes Decedant Ev	ver in U.S.	13. Wes Dec					e - American Indien,
5	1 Never Merried 2 Married	Armed Forces?		If Yes, sp	pecify Cuban	, Mexicen, Puert	pecify Yes or No- o Rican, etc.)	Bled	ck, Whita, etc.
by	3 ☑ Widowed 4 □ Divorced	1 XXYes 2 □ No If Yes, Giva Yeer or Detes:	JUTT	1 ☐ Yes	2 X No	Specify:		Specify	white
	,,			Sa Danadarda Ha	wat Oaswast	1		10h Vind of D	
Completed	15. Decedent's Edu (Specify only highest great	de completed)	10	6e. Decedent's Us (Give kind of w	vork done du	uring most of wor	king	100. Kind of Bu	usiness/Industry
E	Elementery/Secondery (0-12)	College (1-4or 5+))						
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Be	17. Father's Neme (First, Middla, Last)				-0.7		ne (First, Middle,	Maiden Sumem	10)
2	Charles Frederick Schu	ıltz, Sr.				Lola Smith	1		
	19e. Informent's Neme/Reletionship (T	Type, Print)	1	9b. Meiling Addre	ss (Street ar	nd Number or Ru	ral Route Numbe	r, City or Town,	Stete, Zip Code)
	Mrs. Suzanne M. Cooper	(Daughter)		512 Locksle	ev Road	Towson	, Maryland	21204	
- 1	20e. Method of Disposition	(badgitosi)	20b. Plece	of Disposition (N	lame of	I			City or Town, State
	1 XBurial 2 ☐ Cremetion 3 ☐ I			stery, cremetory or		,	14/02/2000	Daltima	una Mararillamal
	4 Donetion 5 Other (Specify,			ood Cemeter	-				ore, Maryland
	21. Signeture of Funeral Service Licens	Jeffrey L.	. Gair	22. Neme e	end Address	of FecilityRUC	< Towson Fi	uneral Ho	me, Inc.
	1050 York Rd. Towson, Md. 21204								
	23a. Part Enter the displace, or comp	plications that caused the	he deeth. D	o not enter the mo	ode of dvina.	such es cardiac	or respiretory en	est.	Approximete
3	disease or condition resulting in death)	θ			. ~		100111	11	1000
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** William Donald Spence 1999 DEC. 2:00 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Highway Unit 110 City Worchester Ocean 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days 219-16-896 Yrs. Director Esp1,05/179A Maryland Usuel Residence of Decedent 10a Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Worchester WD Cita Director Ocean 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Unit 8 21842 U.S. A 10300 Coastal Highway 110 permit. Peges 1 end 2 should be filed within 72 hours after deeth v Depertment of Health end Mental Hyglene. Important: If New 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Exercites const. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Ø Yes 2 □ No If Wes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Steamfitters & Elementary/Secondery (0-12) College (1-4or 5+) Welder Plumbers local 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Bailey Alfred Spence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 10300 Coastal Hig ocean City, MD M. Mavis hway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele 20e. Method of Disposition Dec. 390. 1 Burial 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) awn Cemeter Baltimore 1999 22. Name and Address of Facility Evoing Chappy of Memor 21. Signature of Funeral Service Licensee 6800 sitimore imp 21 ther 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical dmo5 Examiner Due to for as a consequence of) Physician/Medical Examiner buriei-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or as a consequence of): and certificete be execu ettending physicien P.O. Box 68760 the Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 3 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 ☐ Yes No Division of Vital or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Neturel 2 Accident 5 Pending investigation 1 TYes 2 No 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

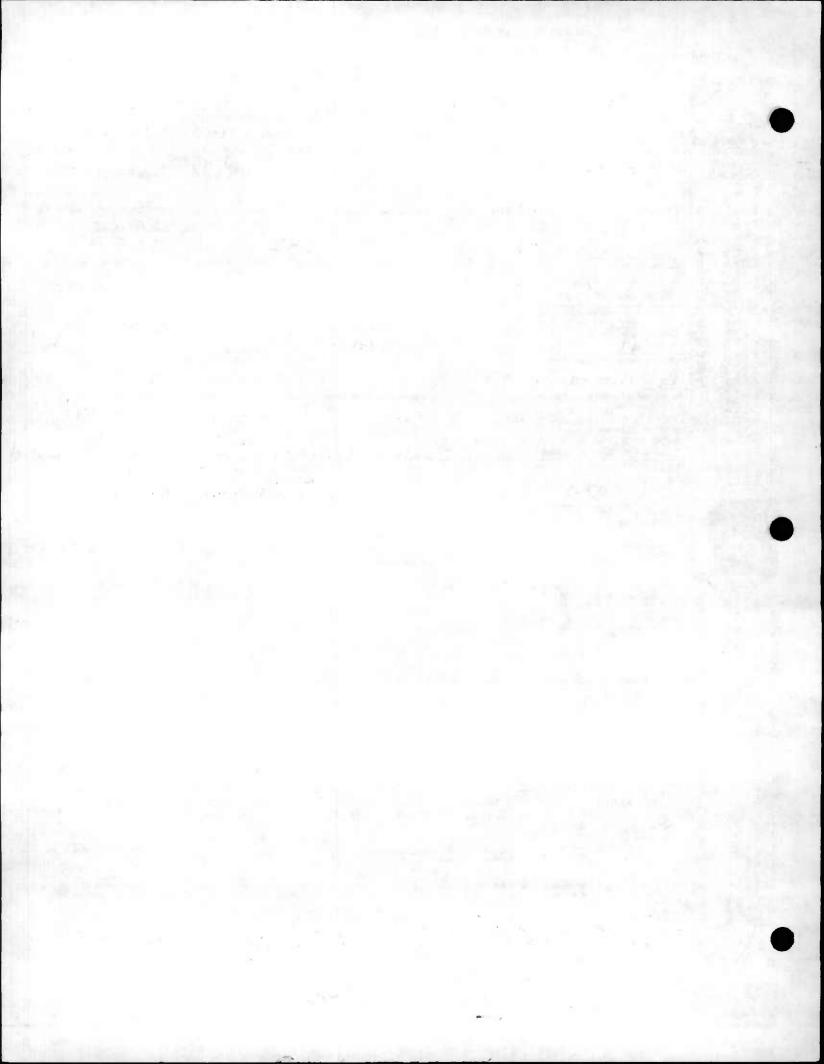
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical (Check only one) To the To the 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) (ous) Ja/156 145E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 3 0 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3. Time of Death Ruth 1. 1999 07:30 PM DECEMBER 25, 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Mach 2 1917 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 M 2 X F 218-01-7490 Pennsylvania Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MI 1 Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? 813-B Dartmouth Ave U.S 12 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 D(No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Oscar Shelly William Mary Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3503 unbelle Terrare Parkville, MD 21234 Edith M. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Dec. 30, 4 ☐ Donation 5 ☐ Other (Specify) ParkvilleimD Harkwood (emeter 1999 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Evans Funeral Chapel SSOO Harford Rd. Baltimoleinip 10 M 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death RIGHT LOWER LOBE PNEUMONIA Immediate Ceuse (Final disease or condition resulting in death) DAYS Due to (or as a consequence of): ATRIAL FIBRILLATION DAYS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) HYPERTENSION YEARS Due to (or as a consequence of) CORONARY ARTERY DISEASE YEARS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown **GLAUCOMA** 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24e. Wes an autopsy performed? 2 NO 1 ☐ Yes 1 ☐ Yes 200 No

Physician /Medical Examiner

The Mospital or Attending Physician: The law requires that the death certificate be executed to 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be deteched for use as the burnarilaristic.

Division of Vital Records, P.O. Box 68760,

Department of Health ar Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

Funeral

Director

ò

238

or Items

Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or les

Saltimore, Maryland 21215-0020

Physician/Medical Examiner 2

Be Completed Medical Certification: To

29a. Certifier

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1 Netural 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es stated.

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

26. Place of Death (Check only one)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29b. Signature and title of certifier

allos

29c. License number D 25886

29d. Date signed (Month, Day, Year)

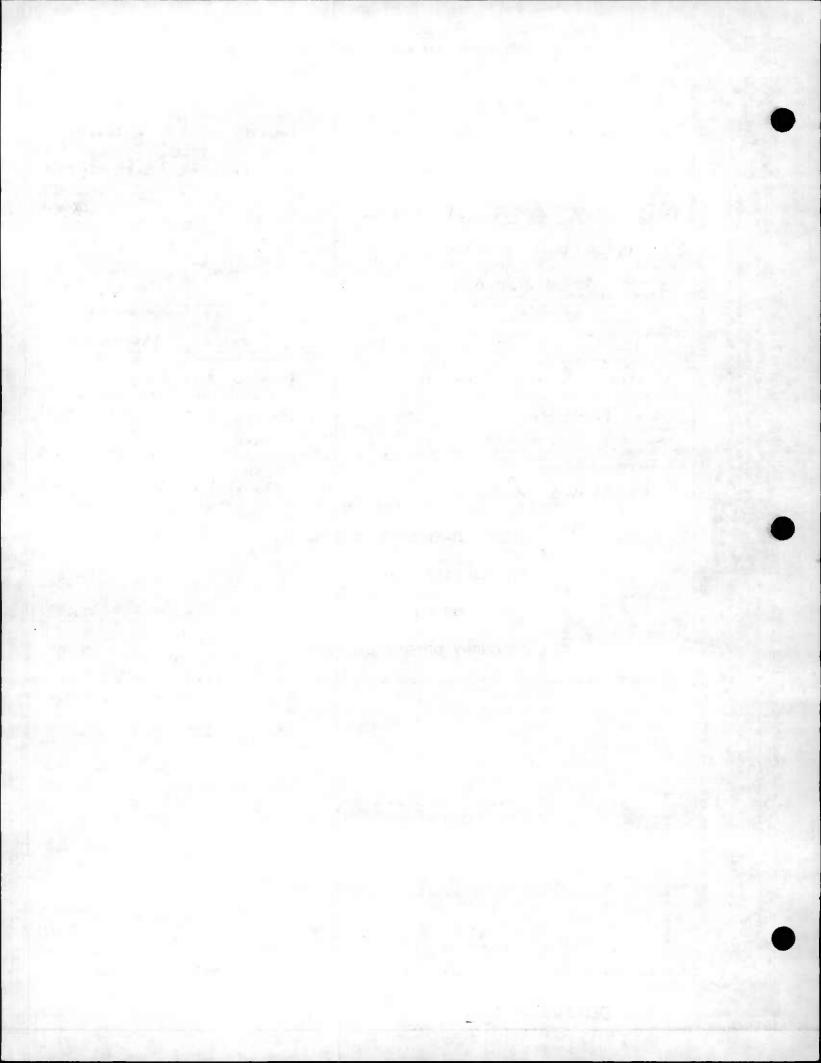
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Dey, Year)

State Registrar

DEC 3 0 1999





DHMH 16 Rev 6/95

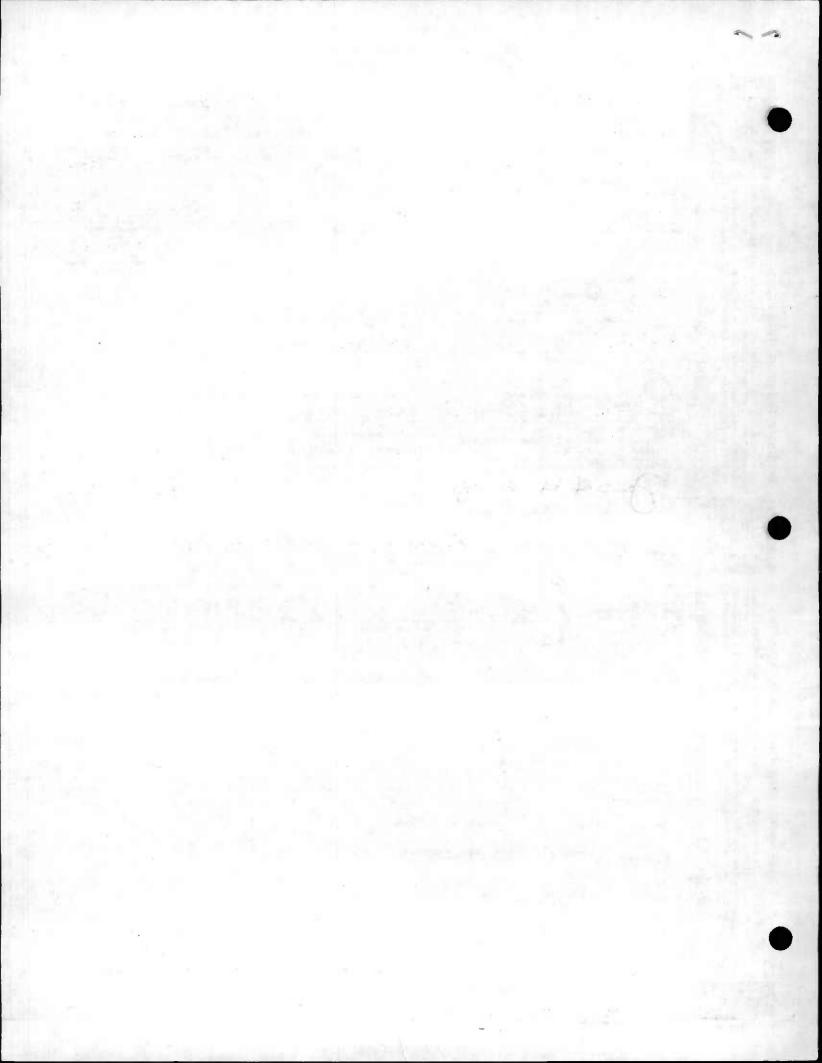
State Registrar 31. Dete filed (Month, Dey, Year)

DEC 3 0 1999

Simmons,

ORIGINAL

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 2. Dete of Deeth / 1. Decedent's Nema (First, Middle, Last) **Physician** 29 harles 12 /Medical 4a Facility Neme (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner cakerest village Care Balto Center Balto . MD. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months 212-01-7453 Usuel Residence of Decedent 83 Yrs. Director 08-13-1916 ms 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Llmits Balto MA 1 ☐ Yes 2 13 No Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8825-1412 Walther Blod USA 21234 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yas 2 No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Nevar Married 2 Married Specify: White 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Supervisor 17. Fether's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be Schmidt Charles Nagel William 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8220-1412 Walther Blod. Baltimore, MD 21234 Shirley K. Schmidt - Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 12 Buriel 2 Cremetion 3 Removel from Stete 12/31/99 Bolancy Valley Memorial Gods 4 □ Donation 5 □ Other (Specify) limonium, 21. Signeture of Funage Service Licery 22. Nama and Addrass of Facility Brian T. Chisholm Funeral Services of Dulaney Valley. PA 200 E Radonia Rd. Timonium, MD 21093 23e. Pert1. Enter the diseesa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical FAILURE TO THRIVE works Examiner Due to (or es e consequence of) Physician/Medical Examiner 16 mos OLON CANCER Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest pue Due to (or es a consequence of): Box 68760. Dua to (or es a consequence of): the P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Tunknown Drostate ancer 1 Yes 2 No Records, 24b. Were eutopsy findings aveileble prior to Be Completed 24a. Wes en eutopsy and reducancer. complation of causa of deeth? certificate 1 ☐ Yes 2 ☐ No Division of Vital Money or Attending Physician: 24 Physician: 24 Physician after death.

Function Director: After this certification of the funeral director; p. 100 physician 25. Was cese refarred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 28c. tnjury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier dical To the Fune completely t (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. Licanse number 2564

State Registrar 8800 Waether

/32. Registrer's Signety

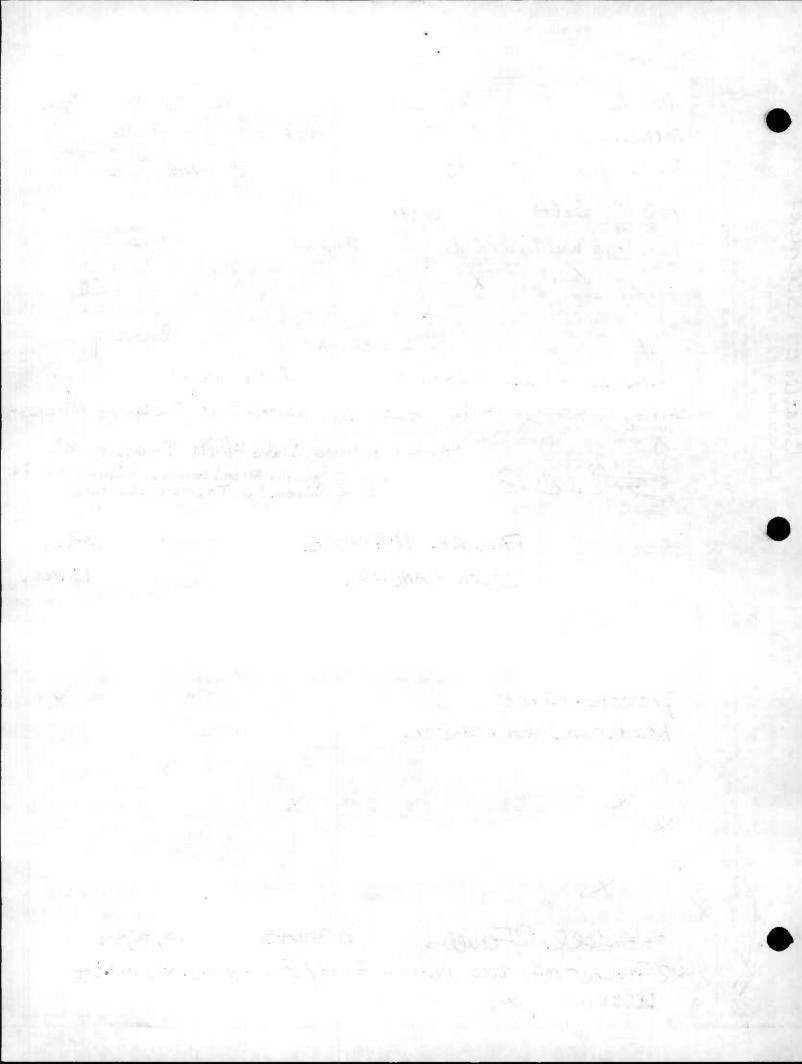
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Baltmore MD 21234

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

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Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40952 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time ol Death Month HENRY FRANCIS STOECKER DECEMBER 29, 1999 6:50 A.M. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth TOWSON BALTIMORE GILCHRIST CENTER 8. Date of Birth (Month, Day, Year) 6/28/22 If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Hours Months M 2□ F Yrs MARYLAND 215-12-1248 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No MD BALTIMORE RIDGELEIGH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1878 YAKONA ROAD 21234 USA 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 XYas 2 No If Yes, Giva Year or Detes: 1 Never Married 2 X Married 1 Yas 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE PIPE CUTTER CROWN, CORK & SEAL 17. Father's Name (First, Middle, Last) 18. Mothar's Nama /First, Middle, Maiden Sumame) KARL STOECKER STOCK KATHERINE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE MARIE STOECKER 1878 RAKONA ROAD BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata N☐ Burial 2, ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JOSEPH CEM. 12/31/99 FULLERTON, MD 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part. Enter the disease, or complications that call, dithe death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cayse on early line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown or sease 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yas 2 No 1 Yas 20 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Sthar (Specify) Haspure 28d. Describe how injury occurred

68760 Physician/Medical 2 Box Records, à Completed Vital å 10 to Certification: Division

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Physician

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Physician

/Medical Examiner

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25. Was casa referre axaminer? 1 Yes 2 N	
27. Manner of Death	5 □ Pending

28a. Deta of tnjury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifi

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1) 304 33

29d. Data signed (Month, Day, Year)

MYMIC 31. Data filed (Month, Day, Year)

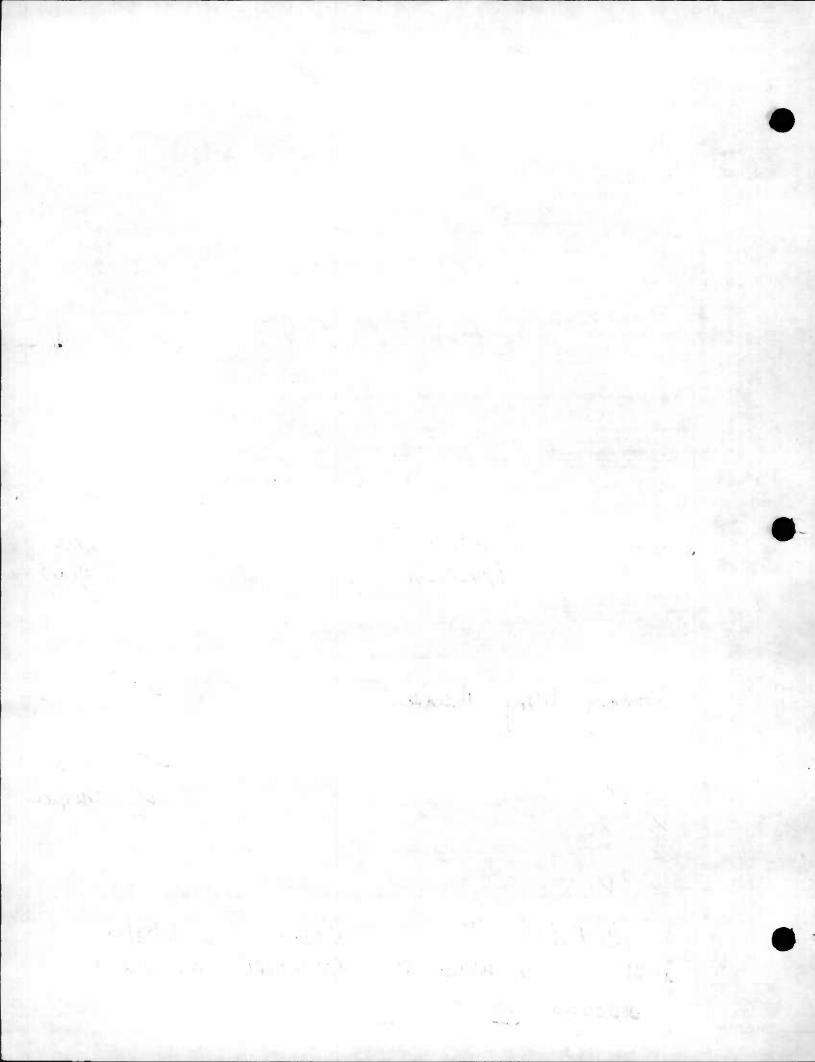
bil death (Item 23a) (Type, Print) CHARLE 32. Registrar's Signature

BALTIMORE

State Registrar

DEC 3 0 1999

oaks



/Medical Examiner The law requires that the death certificate be executed ettending physician and for use as the bunal-tran P.O. Box 68760. Records, Sign Division of Vital or Attending Physician: After this s after death.

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at

e filed within 72 hours after il Hygiene. other than "natural", or ite

permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event obtas.

Physician

3altimore, Maryland 21215-0020

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Funeral

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Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. ISCHEMIC p Completed Be 25. Wes case referred to medical examiner? Medical Certification: To 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Neturel 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12,07,1999 RES-000

30. Neme end address of parson who completed cause of death (Item 23a) (Type, Print)

GOONORAWOLFE STREET BALTIMORE, MARYLAND HUNTER C. CHAMPION, MD

31. Dete filed (Month, Dey, Year) DEC 3 0

32. Registrar's Signeture

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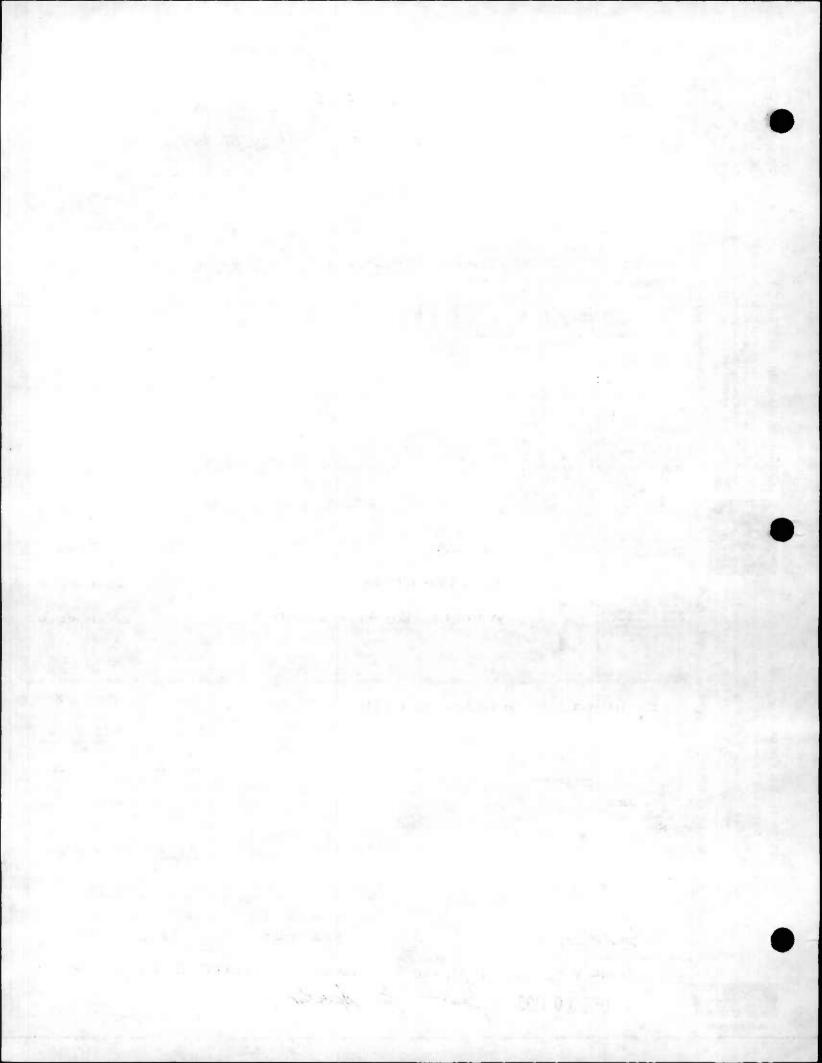
State Registrar

filled in by

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24 hours a Funeral Hospital

To the Vithin 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

								rtificate		Death		Reg. No.	19 4	10954
	Physician		Decedent'a Neme (First, Middle, Last) CHARLOTTE						UT.S	2. Dete of Month DECEM			1999	3. Time of Death
	/Medical		e Facility Nama (If no			nber)		D110		b. City, Town, or L	1		unty of Death	2, 12 7"
> 1	Examiner											BALTIN		
	uneral irector	5	Social Security Number 220–18–777		ex □M 2⊠ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Months I	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, Di FEB. 24	rth ay, Year) ,1912	9. Birth	plece (State or Foreign intry) MD
pu	2	_	Isual Residence of De			10c Ci	ty Town or L	reation						10d. Inside City Limita
Aaryle	28a-f shownorthead at		10a. State 10b. County 10c. City, Town or Location MD BALTIMORE PIKESVILLE									1 ☐ Yea 2 🖔 No		
ith the	or 28e-f	1	10e. Street and Number 10f. Zip Code							10g. Citizen of W			intry?	
ath w				MILEORI						21208		U.S.A		
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and	127 10 tr	L	EILEEN FF		/ DAUGE					L #1108				
Pages 1	= A	2	0a. Method of Disposit 1 ☐ Burial 2 ☐ Ci 4 ☐ Donation 5 ☐	remetion 3		itata	Place of Dispo cemetery, crei BREW YO	metory or other	er plec	CEMETERY	Dete 12/29/9		on - City or T	
permit. Pag Department	Important: any injury once.	-	11. Signature of Funer	Service Lices	-			Name end		301	LEVIN			INC. MD 21208
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death certificata be axe	signed by the attendin d be detached for use d by Physiciar/N	F	ert II. Other significan	rt conditions co		ath but not res	sulting in the u	nderlving cau	se div	en in Part I.	23b. Dld	tobacco uae	contribute	to the cause of death?
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Attending Phy or death.	50		7. Manner of Death	Pending investigation	28a. Data of (Month)		28b. Time o tnjury		. Injun		ng Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred			
5 4	To the Funeral Director: After th completely filled in by the funeral Medical Certification:		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, fact building, etc. (Specify)									ral Route Number,		
the Hospital	he Funeral pletely fille edical C					sis of examina				na, data and place, pinion, death occur				
To the	o the		9b. Signature and title	of position	00		70	29c. L	lcens	e number		29d. Date s	gned (Month	, Day, Year)
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11	N	3	0. Name and address	of person who o	ompleted cause	of death (Iter	n 23a) (Type,	Print)	_	1021			من مر) ' ' ' '
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	State	3	1. Date filed (Month, D		32/Re	gistrar's Signa	ature 4	1					1	
- 1	Registrar		DEC 3	0 1999	1		1	DOORA	120					

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death AMEND#1 PER MD. G778 12-29-99 J.A. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** :10pm JAMES EDWARD JEROME SHIPLEY IV August /Medical 4a Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of De Examiner BAKIMORE If Under 24 Hrs. 8 Hours Min. city HOPKINS HOSPITAL

7. Age (In yrs. last birthday) Johns 8. Date of Birth (Month, Dev. If Under 1 Year 5. Sociel Security Number 9. Birthplece (State or Foreign Country) **Funeral** Days Months 1 M 2 F Unknown Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or itams 23a or 28a-f shorthe Madical Examiner must be notified at mD 1 Yes 2 □ No Director timore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 212 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11 Maritel Stetus 12 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Blace þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4gr 5+) NIA other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) permit. Peges 1 end 2 should be filt Department of Health end Mentel Hy Important: If Itam 27 Ia marked oth any Injury or other treumetic avant Be Unknown Drown 19a. Intermant's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) md. 2/2/7 13 -mother 20b. Plece of Disposition (Neme of 20a Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State Sohns Hopkins Hospita 30-4 Donation 5 Dother (Specify) Disposal 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11. Wolfe St -600 wans 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a conseque PF ST attending physician end for use as the burial-trensit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760. certificete be Physician/Medicai Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by Division of Vital Records. þ 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? Completed After this certificate has 1 TYes 1 Yes To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifice completely filled in by the funeral director, Be 25. Was case reterred to medicel 26. Plece of Deeth (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes edical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 5 Pending investigation Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner es stated.

2 | Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner steted.

State Registrar 29b. Signeture end title of certitier

Name and address of person who

DEC 29 1999

Date filed (Month, Dey, Year)

DHMH 16 Rev 6/95

ORIGINAL

completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

294. Date signed (Month, Dey, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Tinson Darlege 1999 1855 December 20 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days 1 M 2CKF 43 Vrs 215-65-7553 04-15-56 MD Usuat Residence of Decedent 10s. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD NA Baltimore X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1860 E. Fayette Street 21231 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2√ No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HouseKeeping llth Grade Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Tinson, Sr. Lula McDuffie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1748 Carswell Street Baltimore, Maryland co of Disposition (Name of Date 20c. Location - City or Town, State McDuffie Lula 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) Voshell Mem. Gardens 12-27-99 Dundalk, MD 21. Signature of Funerat Service License 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each the Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Se0515 Due to (or as a consequence of): Preumowia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown AID S 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Be 2

Funeral

Director

"natural", or Items 23a or 25a-f redical Examiner must be notifie

Hygiene. ther than out, the Me

permit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy
Important: if them 27 is marked other
any injury or other treumatic event,
bibbs.

Baltimore, Maryland 21215-0020

ettending physician and for use as the buriel-transit signed b Peeu certificate

The law requires that the death certificate be executed P.O. Box 68760 Records, Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

State Registrar

Physician/Medicsi þ Completed 8 Certification: To edical

29b. Signature and title of certifie wolfe 600

1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one)

M.O.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

29c. License number

29d. Date signed (Month, Day, Year) RE5-000 12/20/99

21287

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street North

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature

Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA

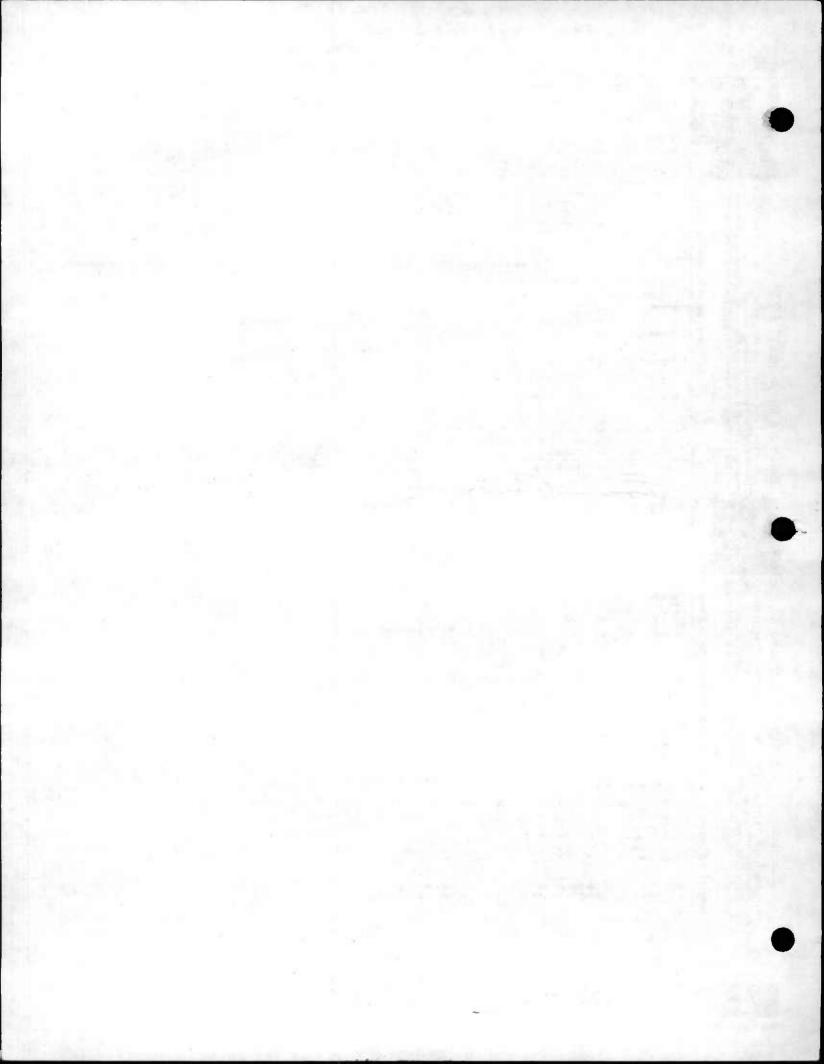
28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Maryland Bultimore

28c. tnjury at Work?

1 TYes 2 TNo

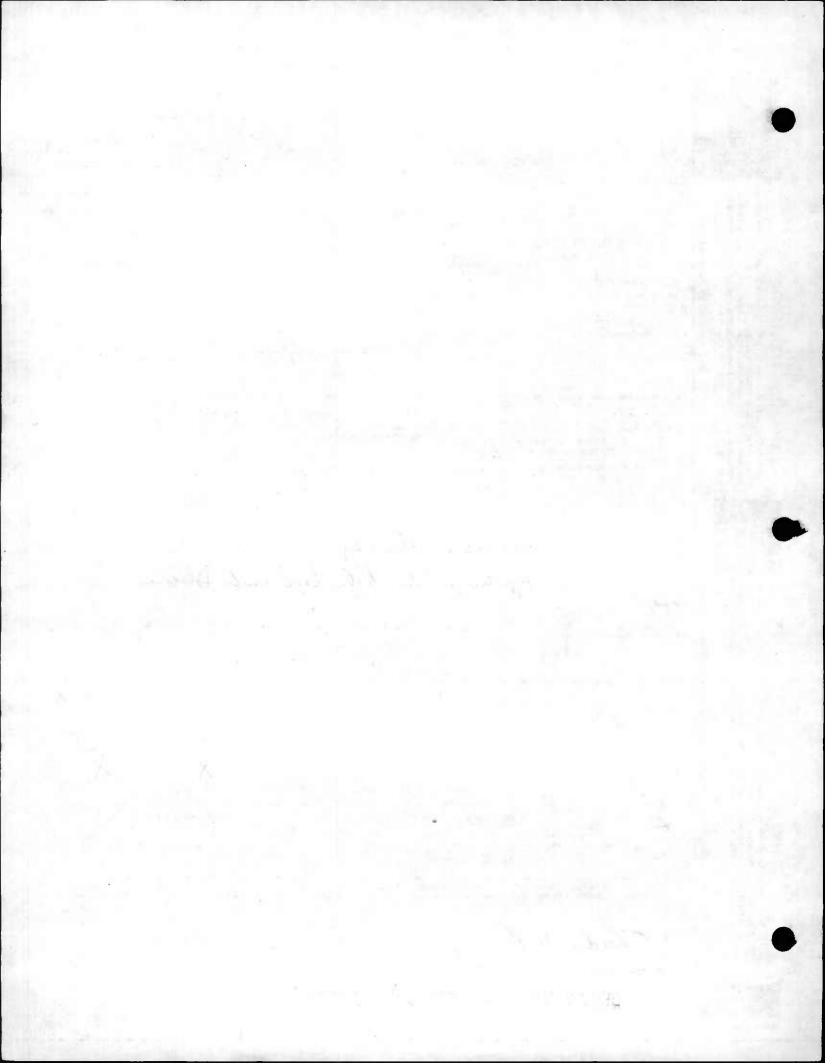


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t d	20a. Method o	f Disposition	3 □Rem	oval from Stat	Ce	metery, cr	position (Name of rematory or other pla		Date 12-30-9	20c. Location	- City or To	wn, State
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Department of Health and Menta Important: if Itam 27 is marked any injury or other traumatic events.	1	ste C	6			1	Second A		Glen H		D 210	61
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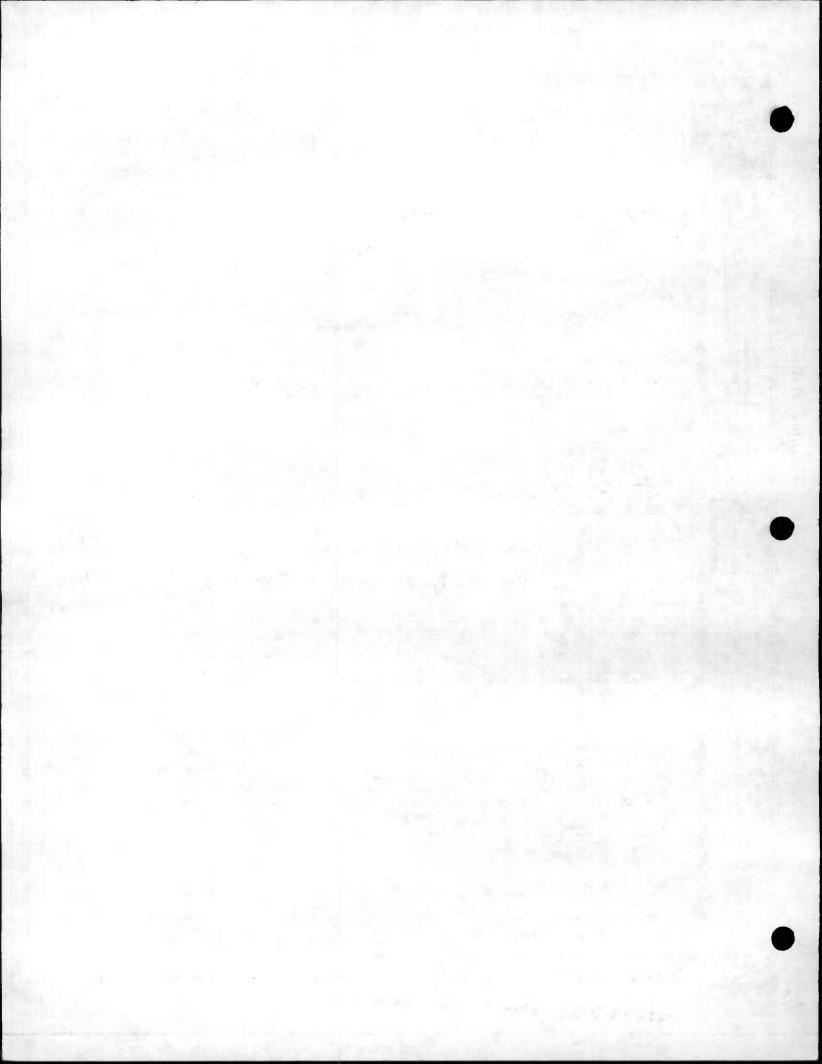
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Physiciar /Medica	Julia I	aylor		of the					DECEMP	Day ER 7.199	Year 9:1	5A.M.
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Director	Usual Residence	of Decedent							1	, -,		
show the	10a. State	10b. County		10c. City, Town or Location								de City Limits
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and Menida		Name/Relationship ((Type, Print)		19b. Mailir	ng Address	(Street a		Rural Route Num	ber, City or Town	, State, Zip Code)	
C TO M N	0.C.M.I	Ε.						et Balt	imore MD	21201		
Battimore, semit. Pages 1 en Department of Heal mycorlant: if item 2 ny injury or other ans.	20a. Method of Dis 1 Burial 2 4 Donation	sposition Cremetion 3 [5 [X] Other (Special	Removel from S	tate C9	nce of Dispo metery, crer	sition (Nam netory or of	ne of ther plea	θ)	Date	20c. Location	- City or Town, Ste	le
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by September 2 - Box 68760, death certificate be associated by selection and for use as the buriel-transit selection.	Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated even resulting in death)	conditions, immediate ferlying or injury	a. Intra	Due to (or		yence of):			male I		Onset	kimete al Between and Death
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DIV To the Hospital or within 24 hours after within 24 hours after completely filled in b Medical Certi		1 Certifying Pt		sis of examinetic					ace, and due to the			use(s)
To the comp	29b. Signature and	d title of certifier				29c.	. License	number		29d. Date signe	ed (Month, Day, Ye	er)
	17	Kerly.	4.16.	4 4			o.c.	M.E.		DECEMBE	R 8,1999	
	30. Name and add	tress of person who	completed cause	death (Item :			enn	Street	, Baltimo	ore, Mar	yland 212	201
State Registrar	31. Date filed (Mod			gistrar's Signatu			oou					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Day Year Month **Physician** 11:00 PM Recember 26 Aubrey J. Taylor 1999 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rosedale If Under 24 Hrs. Hours Min. Franklin Square 5. Social Security Number 6. Huspital Center Baltimore If Under 1 Yeer 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Deys 1 M 2 □ F Yrs. 415-16-3128 Director 87 Aug. 29, 1912 Smithville, TN. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Directo Maryland Baltimore Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? mast be n 902 Cord Street 21220 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yas, Giva Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. 11. Meritel Stetus 1 Never Merried 2 Merried 8 Saltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: p 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 yrs. n/a Electrician Lockheed Martin 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Pages 1 and 2 should be nent of Health and Mental George Washington Taylor Della Hooper 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs.Barbara T. Case (Daughter) 2018 Olde Oxford Ct. Rock Hill, S.C. 29732 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 X Buriel 2 Cremetion 3 Removal from Stata b Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Othar (Specify) Parkwood Cemetery 12/30/99 Baltimore, Md. 22. Neme end Address of Fecility 21. Signeture of Funeral Servica License E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, MD.21087 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting In daeth) /Medical Gastrointestinal Bleeding Examiner Physician/Medical Examiner Dua to (or as a consequence of): eukemia Chronic or Attending Physician: The law requires that the death certificate be executed for use as the bunal-tran Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Ceuse (Disease or injury P.O. Box 68760. thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p page 2 should be Completed 24b. Were autopsy findings avellable prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 X NO 1 Yes 1 Yes 2 No certificate of Vital Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28e. Data of Injury (Month, Dey Year) Division After 1 Neturel 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: Al 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 D Homicide Hospital 29a. Cartifiar 📆 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred et tha time, date end pleca, end due to the cause(s) and manner stated. (Check only one) \$ 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title VECEMBER 26, 1999 30. Name end eddress of person who complated cause of deeth (Itam 23a) (Type, Print) Scan Berenholtz, MD 9000 Franklin Square Prive Baltimore, Maryland 21237 31. Data filed (Month, Dey, Year) 32. Registrer's Signetura State

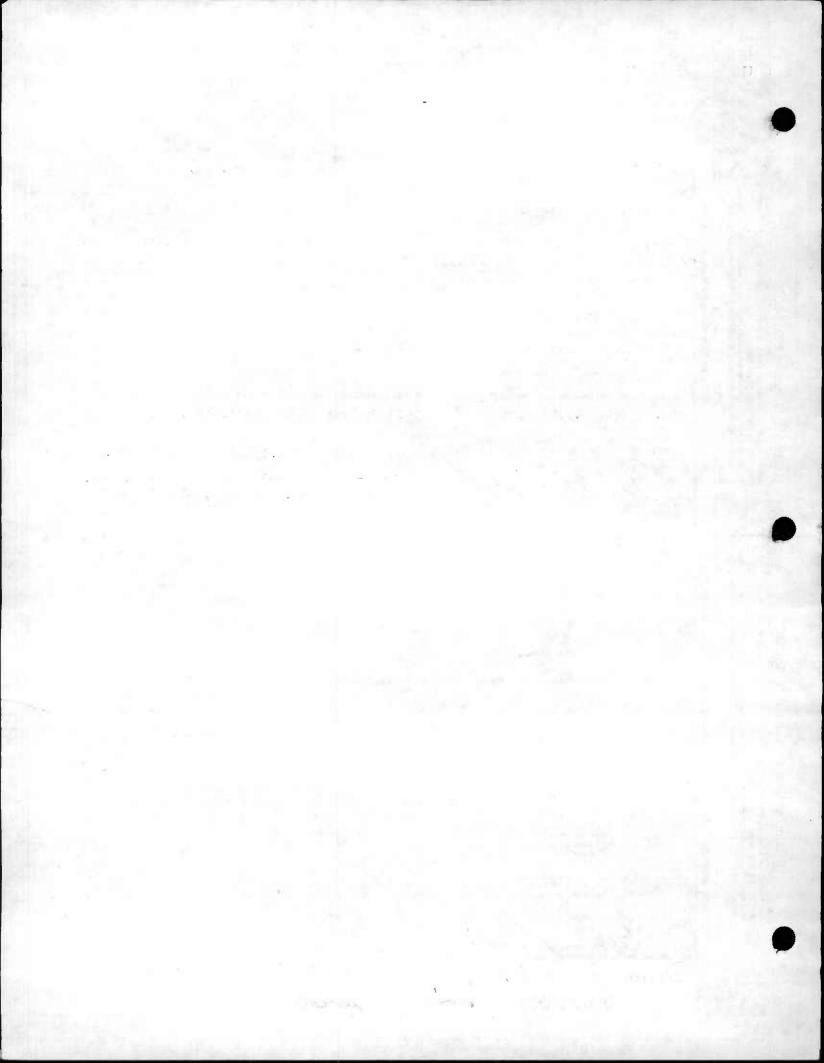
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Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

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ı	4a Facility Name			a number)					ocation of Death		y of Death	
ł	5. Social Security I	YNBROOK Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		TIMORE ler 24 Hrs.	8. Date of Birth (Month, Day		FIMOR 9. Birthr	
	214-54-3	3108	1 ☑ M 2□		Yrs.	Months D	ays Hour		(Month, Day Oct. 24			place (State or Foreigntry) cryland
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L	11. Marital Status		12. Was	Decedent Ever in U	S. 13.	Was Decedent	of Hispanic	Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Re	ca - Americ	can Indien,
		mied 2⊠ Mar	ried 1 TY	d Forces? Yes 2 □XNo is, Give or Dates:		f Yes, specify 1 ☐ Yes 2 🔀			Rican, etc.)	Speci	ack, White, fy:	etc. white
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	17. Father's Name	1, 55, 10, 100,					18. Mo		e (First, Middle, i uline C			
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-	1 ☑ Burial 2		3 □Removel fo	rom State	emetery, crei	natory or other	r place)					
1	21. Signature of F	4		1 Pa		Cemete		2/23/	1999	Balt	imore	, Marylan
	1/6	10	17	fall.					Home of	Dunda:	lk, I	nc.
+	23a Part1 Enter	the disease o	complications the	hat calisad the deat	h Do not ent	7922 Wi	se Ave	as cardiac	ndalk.	Maryl	and	21222
	shock, or her	art failure. List	only one cause	hat caused the deat on each line.					or respiratory on			Approximate Interval Between Onset and Death
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ahow ed at	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location									10	d. Inside City Limits	
28s-f.s cuffed ector	MD 10a. Street and Number	BALTI	MORE	Г	OWSON	401 Tin Code				10g. Citizen of	What Court	1 Yes 2 No
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his certificate has been signed by the attending physician and infrector, page 2 should be detached for use as the burial-trensit and an To Be Completed by Physician/Medical Examiner	Immediete Ceuse (Finel disease or condition resulting in deeth) Sequentielly list condition if eny, leeding to immedie cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Pert It. Other significant of the condition of the came of the ca	medical Pending investigation Could not be determined Certifying Physical Examples	b	Due to Out Injury of Unjury e of Unjury - At ing, etc. (Spec	(or as a consector of the consector of t	equence of): equence of): equence of): underlying cause given to the course of the	26. Plecher: 4 Nry at rick?	f. Individual services of Deeth lursing Horacon and place, and pl	23b. Dld 1 24a. Was performed to the Check only or To and due to the	tobacco use co	pontribute to 3 Prob 24b. We ave ave aconot of the conot	the cause of death the cause of death the cause of death ably 4 Unknow tre eutopsy tindings ilable prior to npletion of cause feeth? Route Number, eted. the cause(s)
Further after death. Further Director, After this certificate has been signed by the attending physician and many fined in by the funeral director, page 2 should be detached for use as the burial-trensit and particle of the control of the contro	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert It. Other significant of examiner? 1 Yes 2 No 27. Manner of Death 1 Naturel 5 Accident 3 Suicide 6 Homicide	medical Pending investigation Could not be determined Certifying Physical Examples	b	Due to Out Injury of Unjury e of Unjury - At ing, etc. (Spec	(or as a consector of the consector of t	equence of): equence of): equence of): underlying cause given the course of the cou	26. Plecher: 4 Nry at rick?	f. In the of Deeth lursing Horn and place, a ath occurred.	23b. Dld 1 24a. Was performed to the Check only or To and due to the	tobacco use co Yes 2 No en eutopsy omed? Yes 2 No one) idenca 6 Ott how injury occu (Street end Num. wn, Stete) cause(s) and m date and placa, 29d. Date signe	24b. We ava con ot o	the cause of death the cause of death the cause of death ably 4 Unknow tre eutopsy tindings ilable prior to npletion of cause feeth? Route Number, eted. the cause(s)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death Month Year Watkins **Physician** Doris 1999 2:14 PM 27 December /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hospital Baltimore Good Samaritan NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 10-08-22 Birthplece (State or Foreign Country) 6. Sex **Funeral** Months Days 10M 20F 229-24-7199 77 Yrs. Director NC Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No MD NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3600 Delverne Road 21218 IISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 Yes 2√No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th Grade College (1-4or 5+) Seamstress Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be and Mental Is is marked of and 2 should be Williams Lillie Joseph 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3403 Cardinal Court Baltimore, MD. 21207 Carol Baker 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete MD 20a. Method of Disposition X Burial 2 Cremetion 3 Removal from State Garrison FOrest VA Cem. 01-02-2000 Owings Mills Other (Specify) 21. Signatur V Funeral Service Li 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Decobitus Ulcer, Sounn Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): physicien and s the burial-tran habetes mellitus Physician/Medical Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Chronic Renal Insufficiency 24a. Wes en eutopsy performed? Completed funeral director, 8 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner?

Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural
2 Accident death. 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

UI

ase released by Charlotte in

State

29b. Signeture and title of certifier

Registrar

DHMH 16 Rev 6/95

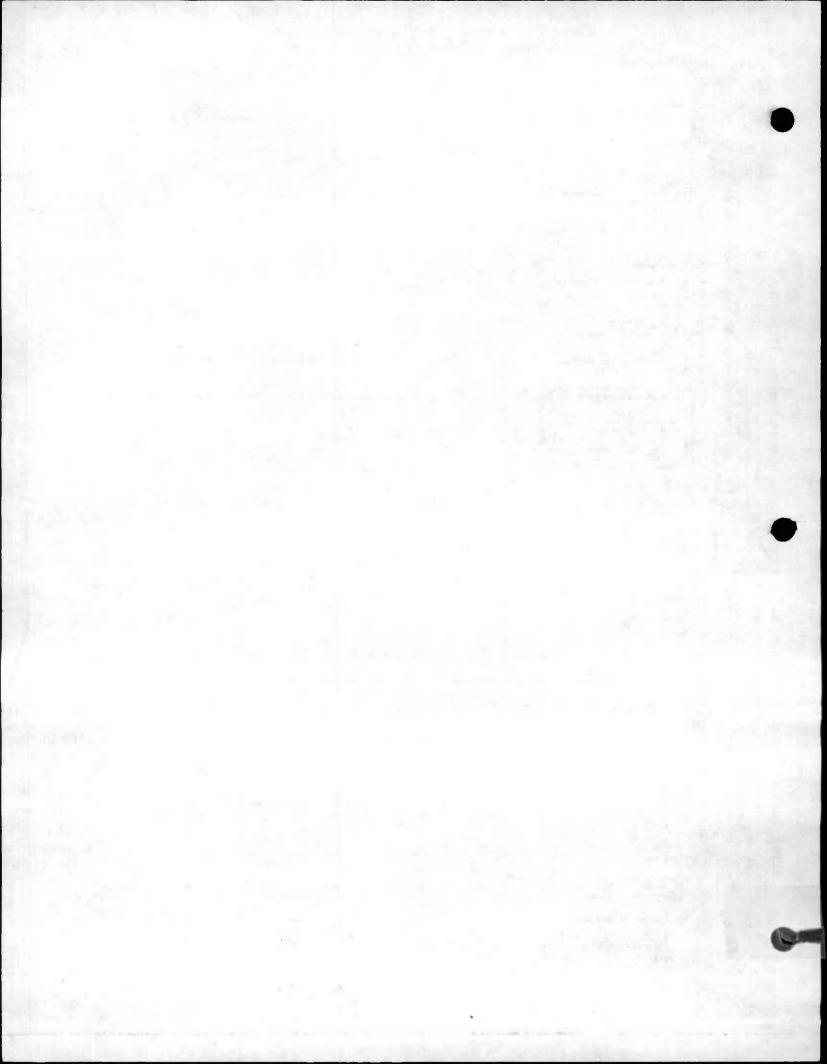
LARSEN, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signeture DEC 3 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

December 28, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day NELL WADE DECEMBEL 24 2015 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CITY THE JOHNS 5. Social Security Number BALTIMOLE HOPKINS HOSPITAL 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Months Days 1 M 2 XF 216-30-5353 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 18 Yes 2 No DAH, MORE 10e Street and Number 10f Zin Code 10g Citizen of What Country? 21213 210 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of HIspanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status I ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BIACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House wife Home MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAVage KOSE Koberl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, Md 230 daughter -aule Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 29 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility / Md. 21213 1129 St N. Caroline 23a. Plum Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or hear failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final · METABOLIC ACIDOSIS DAY disease or condition resulting in death) Due to (or as a consequence of) D. KENAL FAILURE 3 MONITHS DIABETES 1 VEAR Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ™ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ISCHEMIC CARDIOMYUPATHY, TRICUSPID VALUE REGULGA 24a. Was an autopsy

Physician /Medical Examiner

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physician s the burie

signed by t d be detach

After this

Funerel Director:

death.

Hospital or At

Tothe

law requires that the death cartificate be axecu

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

10

Examiner

Physician/Medical

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Be

Medical

State

10a State

Funeral

Director

Show

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health and Mantal Hygiane. Innoctant: If Nem 27 is marked other than "natural", or flee any Injury or other traumatic avant.

3altimore, Maryland 21215-0020

deeth with the Maryland

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ENDOMETRIAL CARCINOMA, HEPATIC FAILURE

CONGESTIVE HEART FAILURE

1 Yes 2 No

1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

Hospitel: 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Naturel 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28b. Time of

28c. Injury at Work?

28d. Describe how Injury occurred

28e. Dete of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29c. License number

29b. Signature and title of certifi-

leiedar mo

RES -000

29d. Date signed (Month, Day, Year) December 26, 1999

30. Name a

who completed cause of death (Item 23a) (Type, Print) 600 N Wolfe Street Baltimore, MARY LAND

Shen Teildw 31. Date filed (Month, Day, Year)

DEC 3 0 1999

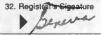
32. Registrar's Signeture

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wade Woodrow Warfield December 24, 1999 2:00 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** 715 East Maple Road Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Nov. 3, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stata or Foraign **Funeral** Days 1 ☐ M 2 ☐ F 86 215-03-5955 Yrs. Maryland Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2ΩNo Directo Maryland Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 East Maple Road ma 23a 21090 II.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises page. Bleck, White, etc. 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: White þ Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Motor Freight 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Transportation Executive Vice President Baitimore, Maryland 18. Mother's Nama (First, Middla, Maiden Sumame) 17. Fether's Neme (First, Middle, Lest) John Randolph Warfield Margaret Pearl Kelly 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Dorothy L. Warfield 715 East Maple Road Linthicum, Maryland 21090 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Mathod of Disposition 1 XX Suriel 2 ☐ Cremetion 3 ☐ Ramoval from State Moreland Memorial Park 12-29-99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licenses Singleton Funeral Home PA ion 1 Second Ave. S.W. Glen Burnie, Maryland 21061 23a. Pert1. Enter the disease, or complications that a the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only one eause or each line. Approximate Interval Batween Onset and Death **Physician** Immediata Causa (Finel disaasa or condition resulting in death) /Medical DONEWAR, ALZERSMENE - TIME Examiner Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disaese or Injury that initiated evants resulting in death) Last Due to (or es e consequence of): Box 68760, Dua to (or as e consequence of) use as the P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 100 3 Probably 4 Unknown or Attanding Physician: The lew requires that CONGESTIVE HORAT PAILURE Records, þ 24b. Wera eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? 2 DENO 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel e Hospital or Attanding 1 24 hours after deeth. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, data and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the causa(s) end mannar stated. 29a. Certifier completely (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 20390 12-27-99

Registrar

31. Date filed (Month, Dey, Year)



DR. CHARLES F. HOESCH, M.D., F.A.C.P., RUSSELL H. MORGAN BLDG., 3FL.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 5601 LOCH RAVEN BLVD., BALTIMORE, MD. 21239

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 60965 AMEND#1 PER MD. G778 12-29-99 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** BABY GIRL WILLIAMS SEPTEMBER 07 1999 15:00 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days UnKnow Yrs Director Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No timore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21206 234 60 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married 1□Yes 20 No Baltimore, Maryland 21215-0020 'netural', or Specify þ 3/901 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mealin DRCs. Elamentary/Secondary (0-12) College (1-4pr 5+) A 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Unknown Greene nthig 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City en Town, State, Zip Code) 1119ms-Mother 6 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hopkins 4 Donation 5 Other (Specify) Disposa 1 408 Johns 21. Signatura of Funaral Sarvice Licensee 5HH-600 n. Walfestbaas mous 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset end Death 3 Physician Immediata Causa (Finel disaasa or condition rasulting in death) /Medical EXTREME PREMATURITY 26 MINUTES Examiner Due to (or as a consequence of): Examiner sician end burial-transit certificate be executed Sequentially list conditions, if any, leeding to immadiate causa. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as e consequence of): Box 68760 Physician/Medical the Due to (or as a consequence of) attending | P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the a should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Tyes 2 No. Division of Vital or Attending Physician; Be 25. Was casa refarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1X Netural 5 Pending invastigation death. 1 | Yes 2 | No 2 Accidant 24 hours efter deat Funeral Director: 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 the 29b. Signatura and title of certifian 29c. License number 29d. Deta signed (Month, Day, Year) D23612 SEPTEMBER 7, 1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar



Piease Type or Print in Black indeilble Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 AMEND ITEM: #16A PER F.H. G778 12-30-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey Month Yeer **Physician** Kwang Yun 27, 1999 December 3:40p.m. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 135 Archimedes Drive Pikesville Baltimore 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 10,1946 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2CXF 374-64-4553 54 Yrs. Korea Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore Pikesville 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Archimedes Drive 21208 "natural", or itema 23a United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Raca - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus parmit. Pages 1 and 2 should be filed within 72 hours after copartment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or than any Injury or other traumatic event, the Medical Evantina. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) FANG 'S RESTAURANT FORMER OWNER FANGS RESTA 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Restaurant anfs Restaurant 4 years 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Lee 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Edward Yun (son) 135 Archimedes Drive Pikesville, MD 21208 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date to Burlel 2 ☐ Cremetion 3 ☐ Removal from Stele
4 ☐ Donelion 5 ☐ Other (Specify) Black Mountain, Mountain View Cemetery Dec. 31,1999 North Carolina 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signeture of Funeral Service Licensee ellner 8728 Liberty Road Randallstown, MD 21133-4784 23a. Part. Enter the disease, or complications thef caused the death. Do not enter the mode of dying, such as cardiac or respirefory erresf, strick, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician fmmediete Cause (Final diseese or condition resulting in deeth) /Medical 6 Months Examiner Due to (or es e consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within a force the force of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequenca of): Box 68760 thet initieted events resulting in death) Last Due to (or es a consequença of) P.0. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, þ 24b. Were eulopsy findings eveilable prior fo Be Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 Yes 2 DANO Division of Vital 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be defermined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide Pleca of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 12/28/90 138409 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1 - Marille 10 21093 SILMEMA FALLS RO

Registrar **DHMH 16 Rev 6/95**

State

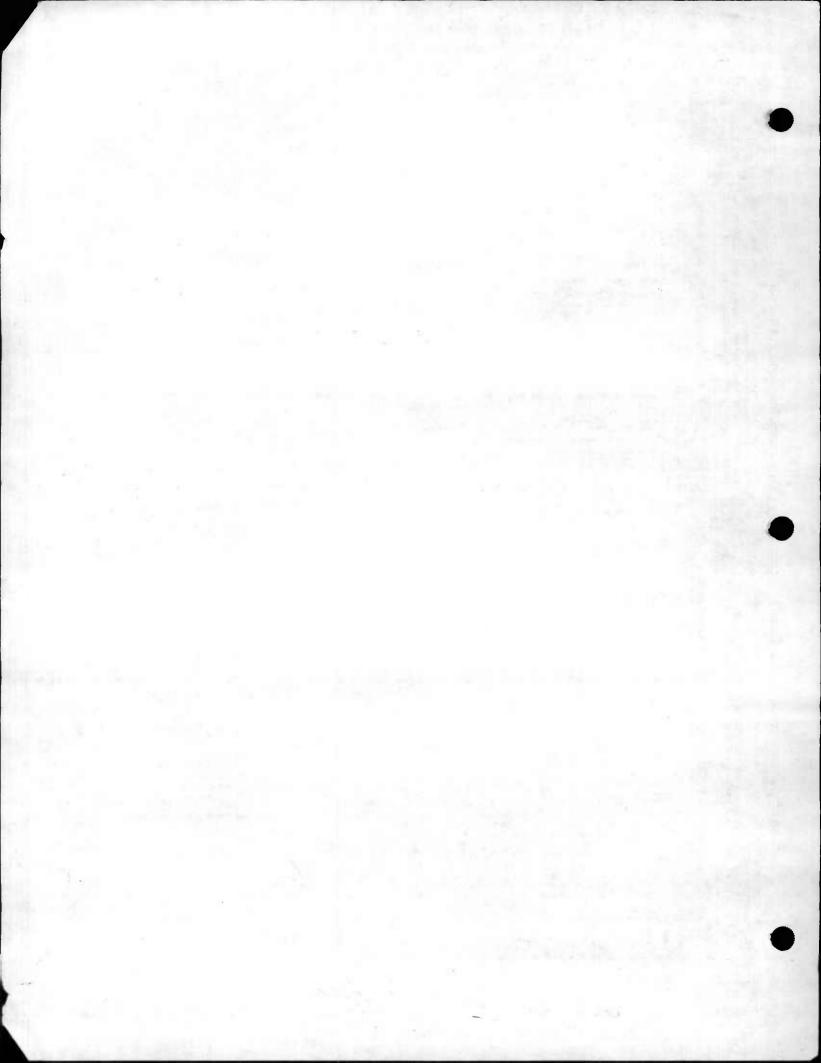
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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Dec 13, T999 **Physician** 4:00 AM Viola Adams Ann. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Prince George's Fort Washington Fort Washington Hospital Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Months Hours 1□ M 2√2 F 578 48 7203 62 Yrs Director Feb 10, 1937 Washington DC Usual Rasidance of Dacedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Fort Washington Directo P.G. MD 10g. Citizen of Whet Country? 10f. Zip Code 10e Street and Number 20744 United States 9205 Ivanhoe Road Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ② No If Yas, Give Year or Detes: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Haalin and Mental Hygiane. Important: If item 27 is merked other than "natural", or iten any Injury or other traumette avent 1 Navar Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alverta Taylor Eugene Gross 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Robert Adams (HUSBAND) 9205 Ivanhoe Road , Fort Washington, MD 20744 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ remation 3 ☐ Removal from State Lee Crematory Dec 14,1999 4 ☐ Donation 5 ☐ Other (Spe Clinton, Maryland 22. Name and Address of Fecility Lee Funeral Home, Inc 6633 Old 21. Signeture of Fune Alexandria Ferry Road, Clinton, MD 20735 234. Partit Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximete Intarval Batwean Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in death) Immediate Cardiac Arrest Examiner Due to (or as e consequence of): Examiner 1 Hour Cardiac Arrhythmia Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Due to (or as e consequence of): 1 Hour Aspiration Pneumonia Physician/Medical Due to (or es e consequence of): 3 Years Multisystem Neurologic Atrophy 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings evailable prior to completion of cause of death? Completed 24e. Was en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese refarrad to medical examiner? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 27. Magnar of Death 28b. Time of 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomleide 1XX Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, end due to the causa(s) and manner stated. 29a. Cartifian edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dec 14,1999 19509 DC ausen 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Shawn Clausen, MD 5401 Western Ave NW, Washington, DC 20015 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State **DEC 1 7 1999** Registrar

DHMH 16 Rev 6/95

death with the Maryland

Baltimore, Maryland 21215-0020

Show

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law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

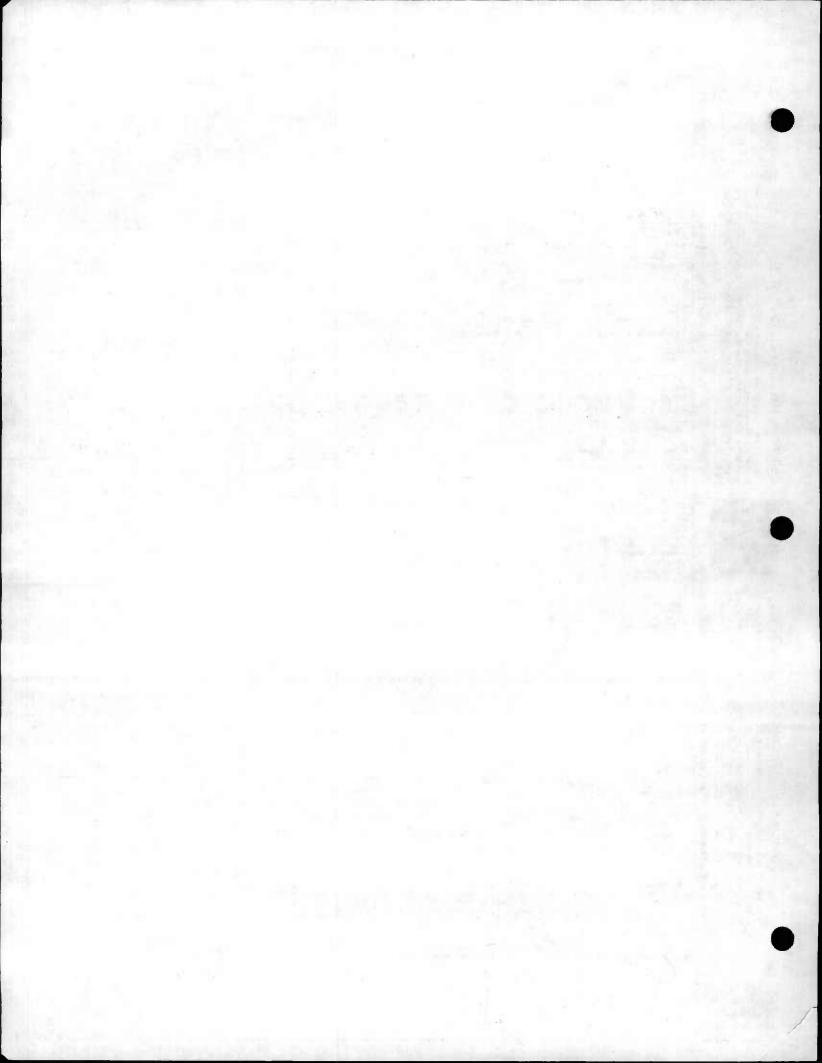
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Henry Godfrey Alley 111

State of Maryland / Department of Health and Mental Hygiene

			Certifica	te of Death		Reg. No.	9 40968			
	1. Decedent's Nama (First, Middle, Las	"			2. Data of D	eath	3. Time of Death			
Physician /Medical	Henry Godfi	ey Alley III			Month Novem	Day Der 26	1999 08:45 AM			
Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Ton	wn, or Location of Dea	7				
4	13942 Clar	ksville Pike	/ westbound	d Hie	ghland	Но	ward			
Funeral Director	5. Social Security Number 6. Security Number 223-64-9888	7. Age (In yrs. 52	last birthday) If Und Yrs. Month:	er 1 Year If Under	Min. 8. Data of B (Month, D Feb 14	rth ey, Year) 1, 1947	Birthplace (State or Foreign Country) Virginia			
2	Usual Residence of Decedant									
nyler ihow	10a. State 10b. County 10c. City, Town or Location									
CTO CTO	Maryland Montgomery Olney									
or 28s-f s	10e. Street and Number		10f. Z	ip Code		10g. Citizen of V	What Country?			
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offer death with the Manylen ritems 23e or 23e-f show the mant to notified at Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Dec	edent of Hispanic Orig	gin? (Specify Yas or N , Puarto Rican, atc.)	0- 14. Rac	e - American Indian,			
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2 ho	15. Decedent's Ed		16a. Decedent's Us	ual Occupation		16b. Kind of Bu	usiness/Industry			
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2 should and Man la marke eumatic	19a. Informent's Name/Ralationship (T		19b. Mailing Addre		or or Rural Route Numi	per. City or Town.	State. Zip Code)			
nd 2 alith en alith e	Sheila B. Alley/Wi				lge Place C					
D TEE	20a. Method of Disposition	20b. I	Place of Disposition (N	ame of	Data		City or Town, Stata			
20-2	1 2 Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Othar (Specify,	Removat from Stata	cemetery, crematory of clumbia Mem	orial Park	1	Clarks	ville, MD			
permit. Pag Department Important: I eny Injury o	21. Signatura of Funeral Service Licens	wis- with					Home, Inc. City, MD 21043			
	23a. Part1. Enter the disaasa, or comp shock, or haart failura. List only of	lications that caused the deal					Approximata Interval Between			
/Medical Examiner Examiner Examiner	Immediate Cause (Final disease or condition rasulting in death)	Dua 10 (or as a consequence of	unes 1:						
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the etter hed for u	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	causa given in Part I.	23b. Did	tobacco use co	ntribute to the cause of death?			
A by detac					1	Yes 2⊠No	3 Probably 4 Unknow			
aw requir			The same			s an autopsy ormed?	24b. Wera autopsy tindings available prior to completion of cause of death?			
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Iclan: The certificate rector, page Co	25. Was casa rafarred to medicat			26. Place	of Deeth (Check only	one)				
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Attending Physic deeth. Cotor: After this by the funerel di	27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Data of Injury (Month, Day Year) (/-26-97	28b. Tima of Injury OB3O M	28c. Injury at Work? 1 ☐ Yas 2 🖼	Driver	28d. Describe how injury occurred Oriver and - and				
or Att	3 Suicide 6 Could not be detarmined	28e. Plece of Injury - At h building, atc. (Special	ome, ferm, street, factor	ory, office	28f. Location City or To	28f. Location (Street end Number or Rural Route Number, City or Town, Stete) UMASVIUS PIVO				
Ne Hospital No Euneral No Funeral plately filled edical Ce		sician: To the best of my kno ner: On the basis of examine and marner stated.				cause(s) and ma	anner as stated.			
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2	30. Name and addrass of parson who o									
+	David K	ave-	111	Penn Stree	et, Baltimo	re, Mary	land 21201			
State Registrar	31. Date filed (Month, Day, Year) NOV 2. 0.10	32. Registrar's Signa	atura 6	/						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Dav **Physician** LATEFAH AHMED 8, DEC. 1999 1:40 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring MONTGOMERY Holy Cross Hospital If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Oct. 23, 1918 9. Birthplaca (Stata or Foraign Country) Arkansas 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ ME 81 Yrs. 066-12-1741 Director Usual Rasidence of Decedent the Marylend ntel Hygiene. ed other than "natural", or itema 23a or 28a-f ahow avant, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 1135 University Blvd, #401 20902 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mentel Hygiene. Important: If Item 27 Ia marked other than "naturat", or Itema 234 any Injury or other traumatic avant, the Medical Examinar masses. Funeral 14. Race - Amaricen Indian, Bleck, Whita, atc. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Specify: Black altimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th Collega (1-4or 5+) Home Homemaker 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be 10 Johnnie Ricks Eugene Ricks 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code 2 0 8 7 9 19e. Informent's Neme/Ralationship (Type, Print) 18408 Honeylocust Cir., Gaithersburg, MD Terry Ahmed (Son) 20b. Place of Disposition (Nama of camatary, cramatory or other place 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from Stata Metropolitan F/Serv.12/13/99 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Light Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Entar the disaasa, or combications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one ceuse on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final Cardiac tamponade hours disaasa or condition resulting in death) Examiner Due to (or es a consequance of): Examiner Diffuse atherosclerosis years ettending physician and for use as the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avants rasulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Dua to (or es a consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy performed? Completed pege 2 s 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Was case rafarred to medicel axaminar? Be 26. Place of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo P 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Panding 1 ☐ Yas 2 ☐ No invastigation after death. 2 Accident Director: A 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 ☐ Homicida 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, data end place, and due to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edicai 29a. Cartifian (Check only one)

State Registrar 31. Data filed (Month, Dey, Year) **DEC 13** 1999

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30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

29b. Signatura and titla of certifier

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32. Registrer's Signature

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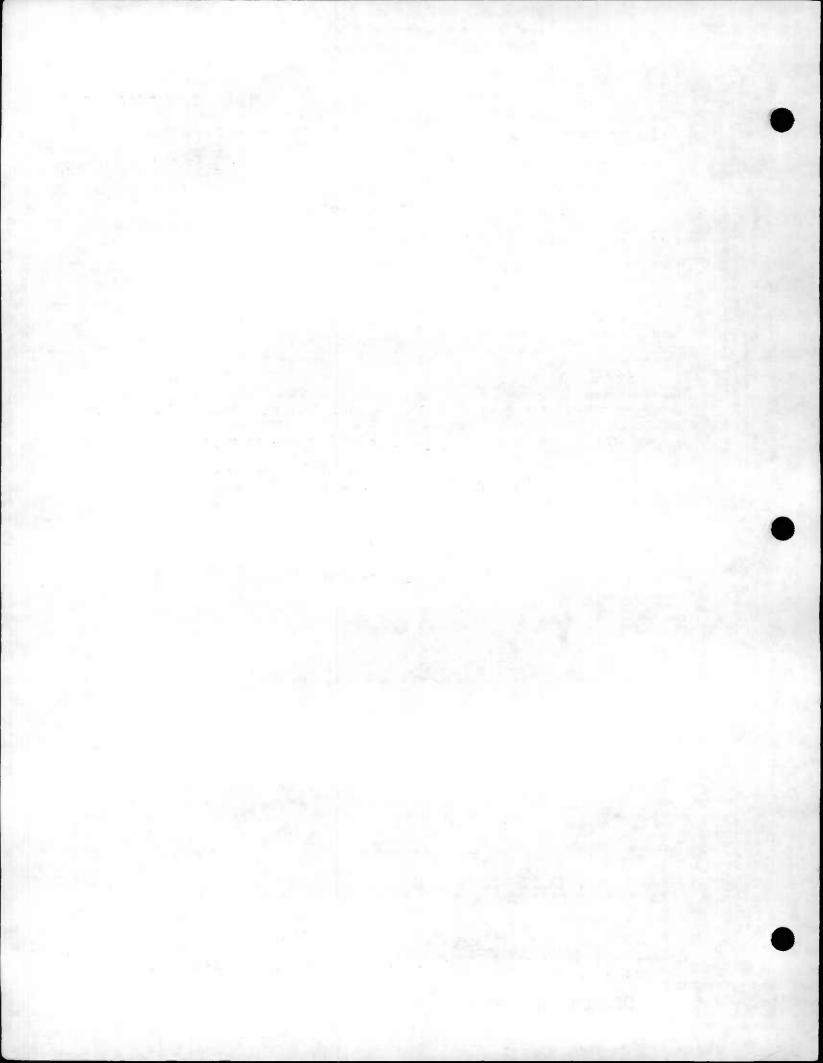
Martha S. Saavedra, M.D. 10313 Georgia Ave., Silver Spring, MD

29c. Licansa number

D0041173

29d. Data signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month 9:40 AM ETHEL ALLEN DECEMBER 10, 1999 MOORE 4a Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth SANDY SPRING MONTGONERY SHARDN NURSING HOME If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) Aug. 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sax 9. Birthplaca (Stata or Foraign Months Days Hours 1□ M 2√2√F Yrs. 038-12-2118 87 Providence, RI 1912 Usual Residence of Decedent 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Montgomery Sandy Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 18201 Slade School Road 20860 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas ②☐ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: 3 ☐Widowed 4 ☐ Divorced White Yaar or Datas: 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middla, Maidan Surnema) 17. Fethar's Name (First, Middla, Last) Humphrey Moore Sarah Garside 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) Donald Allen (Son) 27 W. Marshall Dr. Poughkeepsir, NY 12601 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Poughkeepsie Rural Cem. Poughkeepsie, NY 21. Signature of Funeral Service Licenses 22 Name and Addrass of Facility Auchmoody Funeral Home 126 Main Street Fishkill, NY 12524 enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, or heart failure. Lift only one cause on each line. Approximata Intervel Between Onsat and Death Immediate Ceuse (Final disaese or condition resulting in deeth) . CONGESTIVE HEART FAILURE ATHEROSCLEROTIC HEART DISEASE Due to (or es e consequance of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1 DIABETES MELLITUS thet initiated events rasulting in death) Last Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ALZHEIMER'S DISEASE 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy 28 No 1 Yas 2 Tho 1 □ Yas 26. Placa of Daath (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examine I must be notified as

other than

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any Injury or other trauments

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filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner

certificate be executed pue the buriel-tran ettending physician for use es the burie signed by the e page 2 certificate Attending Physician: director, this funeral After deeth. i or Attendi efter deeth Director: A To the Hospital or Atta-within 24 hours efter der To the Funeral Director completely filled in by the

P.O. Box 68760,

Division of Vital

þ Completed Be

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29a. Certifier

(Check only one)

Physician/Medical 2 Certification:

25. Was casa refarred to madical 1 Yas 2 No

27, Mannar of Death 5 Pending invastigation 1. Naturel 2 Accident

3 Suicida 6 Could not be 4 Homicida

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) Injury

and mannar statad.

28b. Tima of

28e. Placa of Injury - At homa, farm, straet, factory, office building, afc. (Spacify)

28c. Injury at Work? 2 🗌 No 1 Yas

Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 28d. Dascribe how Injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

🖆 Certifying Physicien: To the best of my knowledge, deeth occurred at tha time, date and plece, and dua to tha causa(s) and mannar es stetad. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29c Licansa number 29d, Data signed (Month, Dav. Year)

29b. Signatura and titla of certifiar

ATTENDING PHUSICIAN

D42046

December 10, 1999

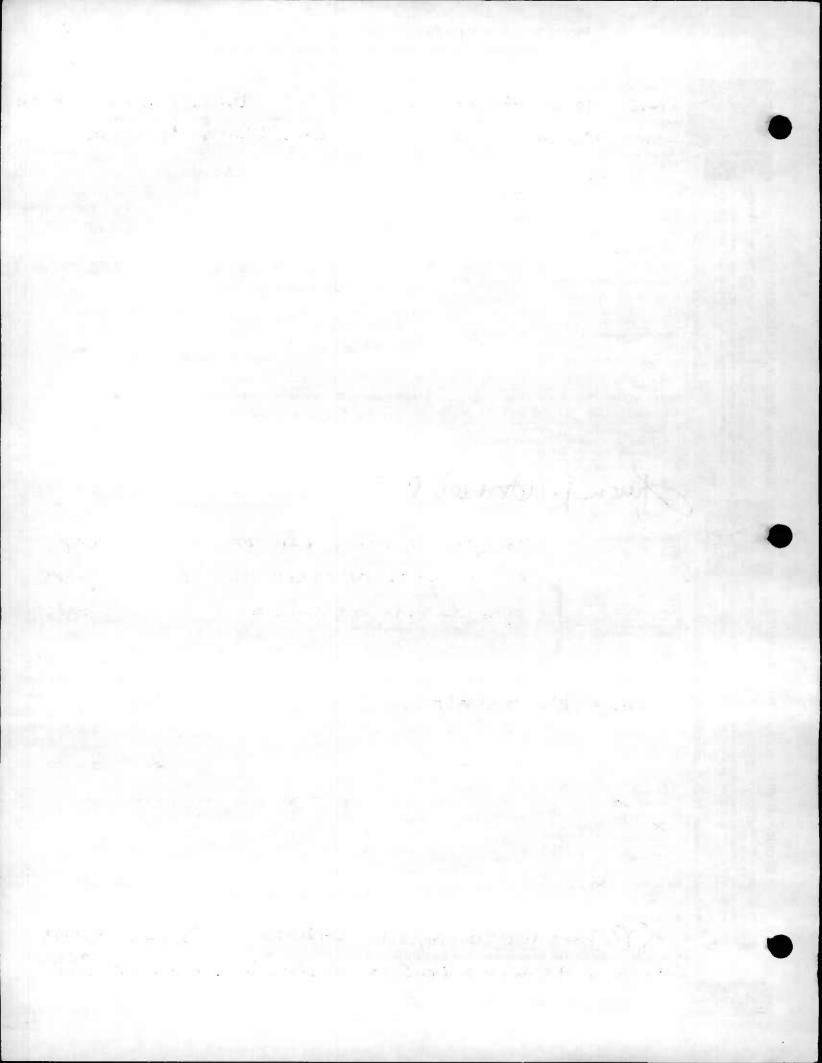
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

20860 GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 31. Data filed (Month, Day, Yaar)

State Registrar

DEC 16 1999

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Day Month Dee J. Alley December 15, 1999 11:49 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington Adventist Hospital Takoma Park r Wunder 24 Hrs. 8. Hours Min. Montgomery If Under 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 1⊠M 2□ F Yrs. 577-07-6419 July 30, 1917 Kentucky Usuel Rasidenca of Decedant 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland | Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6700 Belcrest Road #1007 20782 USA 14. Rece - Amarican Indien, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detas: 1 Yes 2 No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced White WW II 16e. Dacadent's Usuei Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) 5+ Budget Analyst Federal Government 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Dominic Alley Mattie Elliot 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20782 19a. Informent's Name/Relationship (Type, Print) Patricia A. Alley (daughter) 6700 Belcrest Road #1015 Hyattsville, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca, 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Cemetery 12/17/99 Brentwood, Maryland 21. Signature of Funeral Service Lic 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Pert1. Enter tha shock, or haart filler Approximete Intarvel Between Onset end Deeth Immediete Ceusa (Final disease or condition rasulting in daeth) Dua to (or es e consequança of) Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24a. Wes en eutopsy

Physician /Medical Examiner

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Certification:

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Pages

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

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Division Attanding ŏ

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Department of Important: If any injury or once.

Director

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the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted avants resulting in deeth) Lest þ

								1□ Yes 2☑No	1 ☐ Yas 2 ☐ N			
25	Wes case referred to medical examiner? 1 ☐ Yas 2 ☐ No		26. Piece of Deeth (Check only one)									
			Hospitel: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor				oma 5 Rasidenca 6 Other (Specify)					
	Manner of Deeth Naturel Accident	5 Pending investigation		28b. Time of Injury	М		Injury et Work? 1 Yes 2 No	28d. Describe how injury occurre	d			
	3 Suicide 4 Homicide	6 Could not be datarmined	28a. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)					28f. Location (Street end Number or Rurel Route Numb City or Town, Stata)				

29a. Certifier Contrying Phyeician: To the best of my knowledga, daath occurred at the time, data and pieca, and due to tha causa(s) and menner es stetad. (Check only one) Medical Exeminer: On the bests of examination end/or investigation, in my opinion, daath occurred at the time, data and place, and due to the class(s) and menner stated.

29c. License number 29d. Date signed (Month, Dey, Year)

ddress of person who completed cause of deeth (Itam 23a) (Type, Print) 30. Nema end JEFREY 17 FLMAN

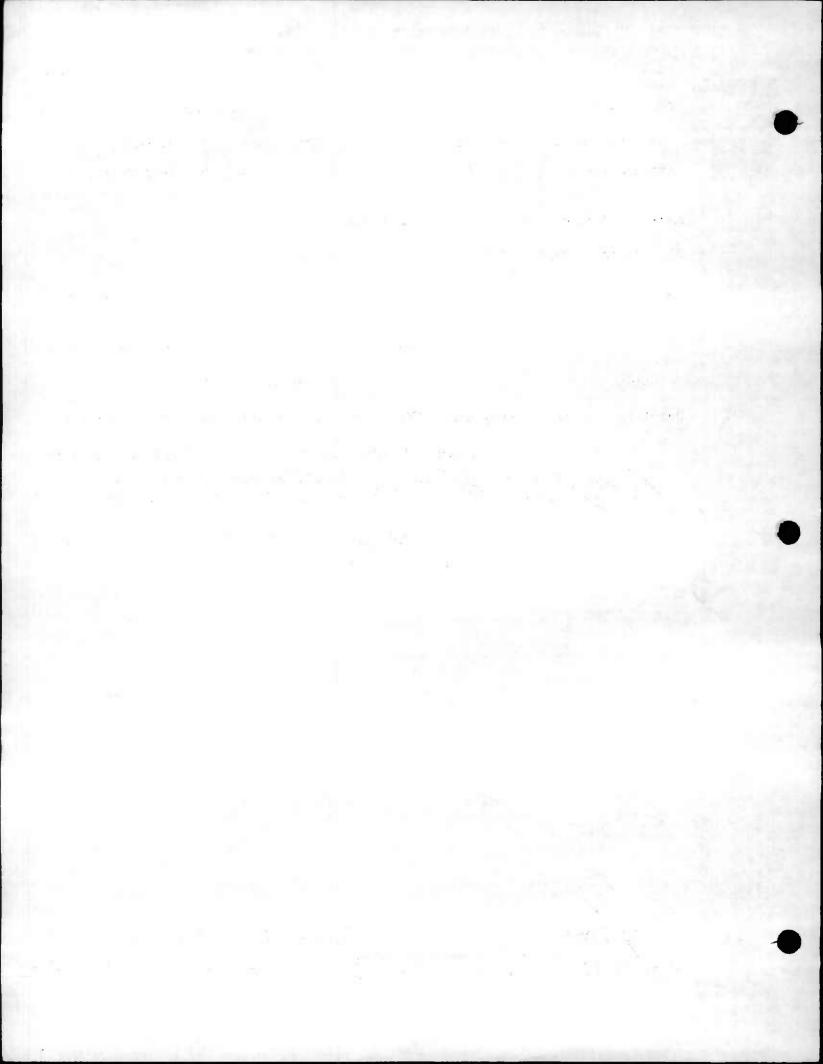
31. Deta filed (Month, Dey, Year) State DEC 7 1999 Registrar

nd title of certifier

29b. Signature

32. Pegistrer's Signeture

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 90 1. Decedent's Name (First, Migdle, Last) 2. Date of Death Month DELEMBER 11, 1999 Cation of Death | 4c. County of Death Murrawat 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) BAltimore City Johns 7. Age (In yrs. last birthday) H Und 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day, May 14 6 Sax 9. Birthplace (State or Foreign 1□ M 21XF 46 Yrs. Pakistan 226-41-1118 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√No Maryland Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15107 South Jenkins Court 20607 Pakistan 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married 1 Yes 2 No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mumtaz Hussain Mumtaz Bibi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nazim A. Alvi (husband) same as #10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MD National Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 12/13/1999 Laurel, Maryland 21. Signature of Funeral Service Licer Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) NORKS Due to (or as a consequence of). Liver DISEASE Stage Due to (or as a consequence of): tepatitis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

attending physician and for use as the burial-transit

1 signed by th.

certificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director,

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital

Physician/Medical Examiner

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Completed

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Medical Certification: To

Physician

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10a. State

Funeral

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permit. Pages 1 and 2 should be illed a Department of Health and Mental Hyges important: if less 27 is marked other the any injury or other traumetic and injury or other traumetic.

3altimore, Maryland 21215-0020

Director

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

1 Yes 2 No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 5 Pending investigation

Hospital: Impatient 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 XNo

26. Place of Death (Check only one)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Vigilance - Medicine Housestaff 29c. License number RES-000

29d. Date signed (Month, Day, Year) December

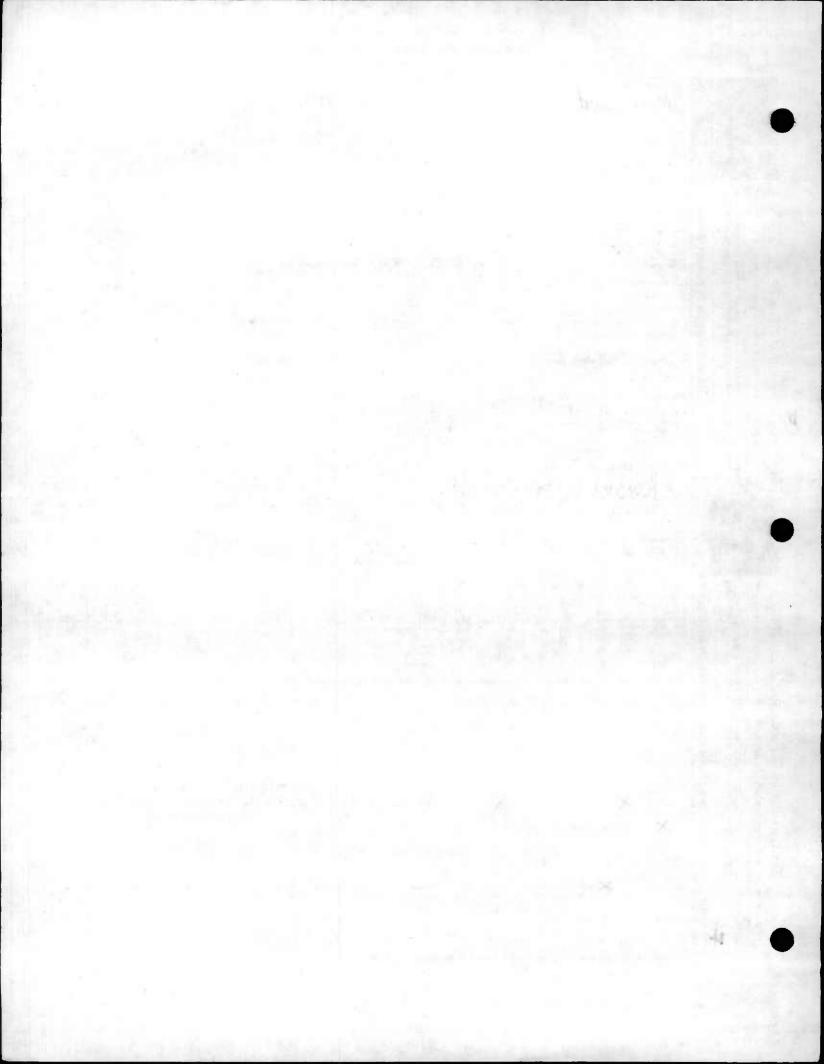
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL, 600 N. WOLFE Street, Baltimore C.PGART VIGILANCE 31. Date filed (Month, Day, Year)

State Registrar

DEC 13 1999

32. Registrar's Signature oaks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name /First Middle Last 2. Dete of Death Month 3. Time of Death Year **Physician** 7:00 AM Elizabeth M. Anders 16 1999 Dec. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Deeth Examiner Holy Cross Nursing and Rehabilitation Center Burtonsville Montgomery 7. Age (In yrs. last birthday) | ff Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Yrs Director 285-10-6353 Illinois July 10, 1912 **Uauat Residence of Decedent** 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Montgomery Silver Spring 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1900 Armond Lane natural, or items 23s 20905 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Merital Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural, or than any Injury or other traumatic avant, the Medical Exempted DAGE. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 2 yrs. Elementery/Secondery (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kaburick Lila Hayes 19a. Informant's Neme/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1900 Armond Lane, Silver Spring, Md. 20905 Arthur J. Anders / Husband 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 1999 Beltsville, Md. 21. Signature of Funeral Service Lice 22. Neme and Address of Fecility Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. 209

23e. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each fine. Approximate tntervat Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Pneumonia Examiner 1 week Due to (or es a consequence of) Physician/Medical Examiner attending physician and for use as the bunal-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No Cerebral Vascular Accident þ cate has been significant category. 24b. Were eutopsy findings eveilable prior to Be Completed 24a. Wes en eutopsy Arteriosclerosis Cardio Vascular Disease completion of cause of death? certificate 1 Yes NO No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director; I 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2♥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 1 Neturel
2 Accident 5 Pending investigetion 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide

P.O. Records. Division of Vital To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

10

State Registrar

Medical

29b. Signature and title of certifier

29c. License number D00053528

1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) December 16, 1999

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Daphna Henkin, M.D., 2309 Shorefield Rd., Wheaton, MD 20902

28e. Pteca of Injury - At home, term, street, factory, office building, etc. (Specify)

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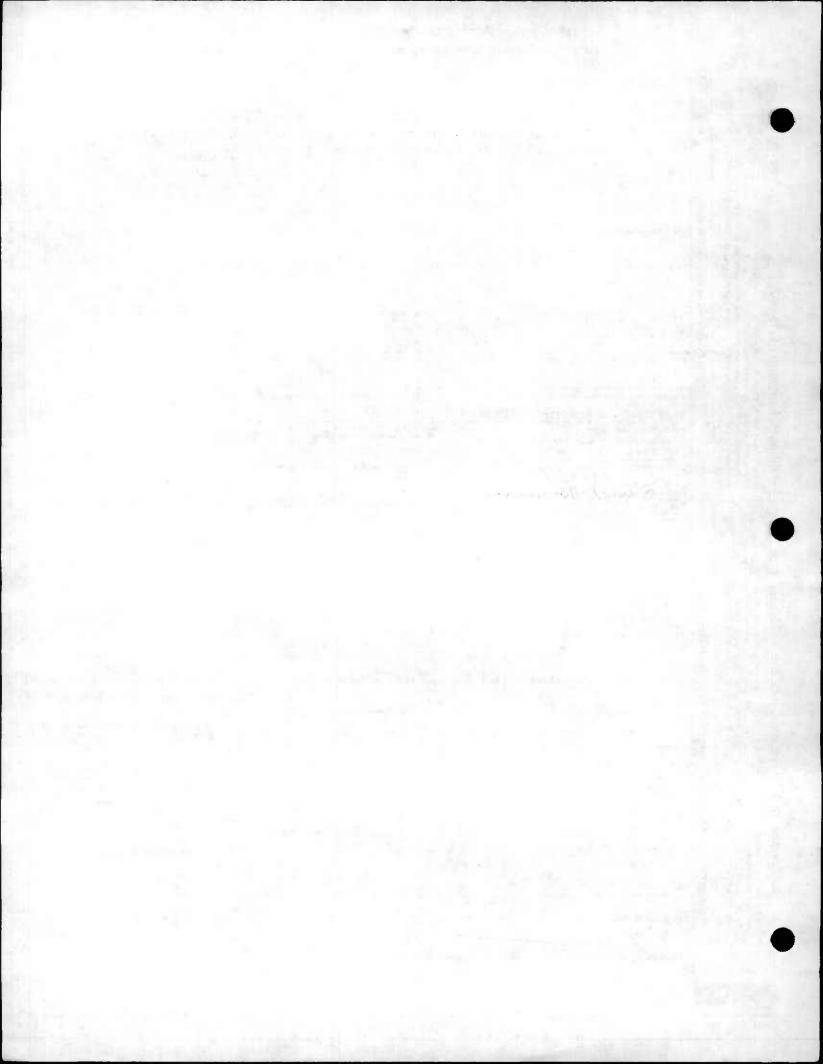
31. Date filed (Month, Dey, Year) 7 1999

4 Homicide

(Check only one)

29a. Certifier

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Date of Death Month Day Vase **Physician** Joan M. Andrew 1999 11, December 11:30 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year H Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Yrs Director 081-20-5016 74 July 26, 1925 New York Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2KINo Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6303 Tulsa Lane 20817 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 Ñ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Š White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 4 Dog Breeder Self-Employed parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic events. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Meenan Edith Bermingham 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh S. Andrew/Husband 6303 Tulsa Lane, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Dec. 15, Silver Spring, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 Maryland 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/ 21. Signetura of Fugarel Service Licensee Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue MO1126 Bethesda, Maryland 20814-3501 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on sech fine. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical 5005.5 Examiner Due to (or es a consequence of): Examiner 1.75 Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest and Box 68760, temoral Physician/Medical Due to (or es a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 2 1) Yes 2 No 3 Probably 4 Unknown should be det Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Wes casa referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of tnjury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending 1 Yes 2 No death. investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours after filled in Funerel Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

State Registrar

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31. Dete filed (Month, Dey, Year) 14 1999 DEC

Hugh H. Trout, III,

30. Neme end andress of person who completed cause of death (ftem 23a) (Type, Print)

29b. Signature and title of certifie

M.D. 32. Registrar's Signature

8218 Wisconsin Avenue, #204, Bethesda, MD 20814-3107

29c. License number

D0028780

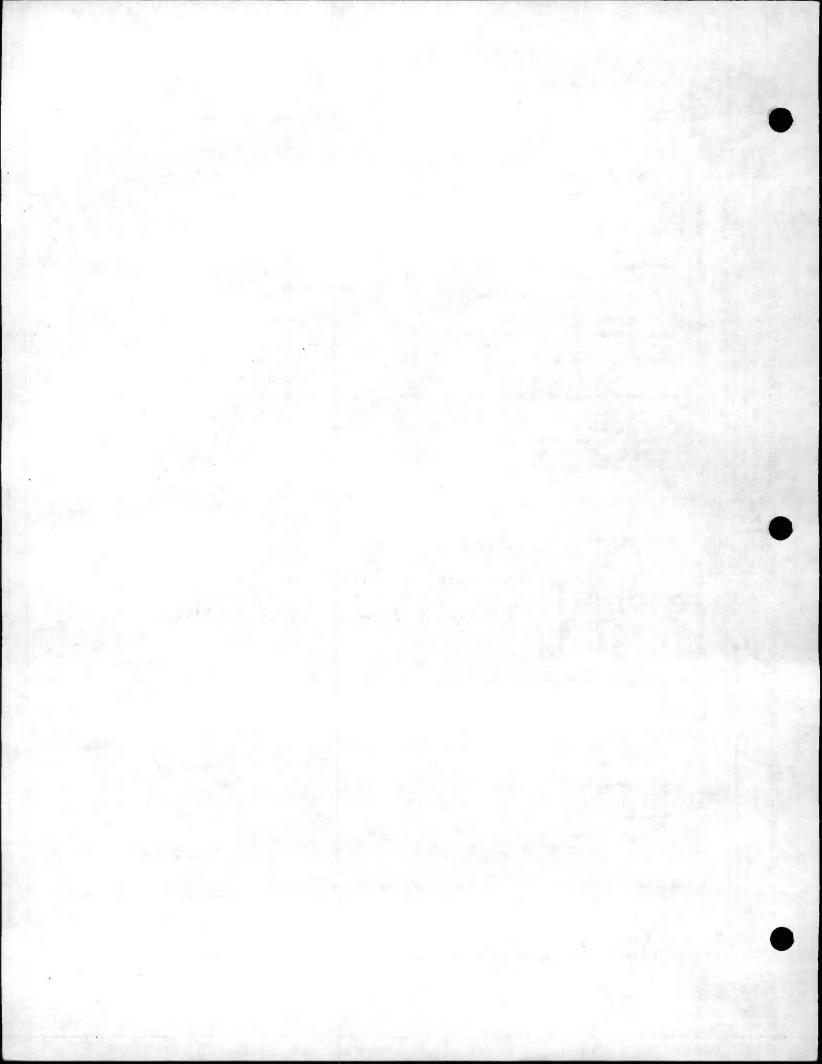
29d. Dete signed (Month, Day, Year)

December 12, 1999

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month Dey B 1999 1245 PM BRINEL A. ASHLEY 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) 1□M ŽCXF Yrs. 212-68-1795 54 JAN. 18, 1945 JAMAICA Usuel Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 20 No MARYLAND | PRINCE GEORGES SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20903 UNITED STATES 1200 QUEBEC STREET 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 11, Merital Status 1 Never Merried 2 Married 1□ Yes 2Ñ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 SECRETARY FEDERAL GOVERNMENT 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) SYDNEY ASHLEY LILLIAN WELLER 19e. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 1200 QUEBEC STREET SILVER SPRING, MD 20903 BEVOLIN ASHLEY/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cramation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) GEORGE WASHINGTON 12/17/99 ADELPHI, MD 21. Signature of Funerel Service Licenses 22 Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. ol nemy 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximeta Intarvel Between Onsat and Daath Immediate Causa (Final diseese or condition resulting in deeth) 4 weeks herabic memperence bmos metastatec breast Concer Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Beau 1 Ves 2 No 3 Probably 4 Unknown metasteses 24b. Were eutopsy findings avellable prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona)

Physician /Medical Examiner

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certificate

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After

e Hospital or Attending 24 hours after death. e Funeral Director: Aft

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Completed

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Certification: To

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Physician

/Medical

Examiner

10a. Stete

Funeral

Director

iral", or items 23s or 28s-f show Examiner must be positing at

natural, or items

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nu sny injury or other traumatic event, the Media once.

death

filed within 72 hours after

21215-0020

Baltimore, Maryland

Box 68760. certificate be

P.O.

Records.

of Vital

Division

Director

Funeral

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Completed

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Examine Sequentielly list conditions, if eny, laeding to immadiata cause. Enter Underlying Causa (Disease or injury that initieted evants resulting in death) Lest Physician/Medical à

> 25. Was case referred to medical exeminer? 1□ Yes 20 No 27. Manner of Death 1 Shartural 2 Accident 5 Pending

investigation 6 Could not be determined

mars O welten

DEC 13 1999

Hospital: 28b. Time of 28e. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

grantelt MD 20770

1 TYes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Certifier
Check only
C gnature and title of certifian

3 Suicide

29a. Certifier

4 Homicide

29c. License number D23743 29d. Data signed (Month, Day, Year) 12-8-99

State

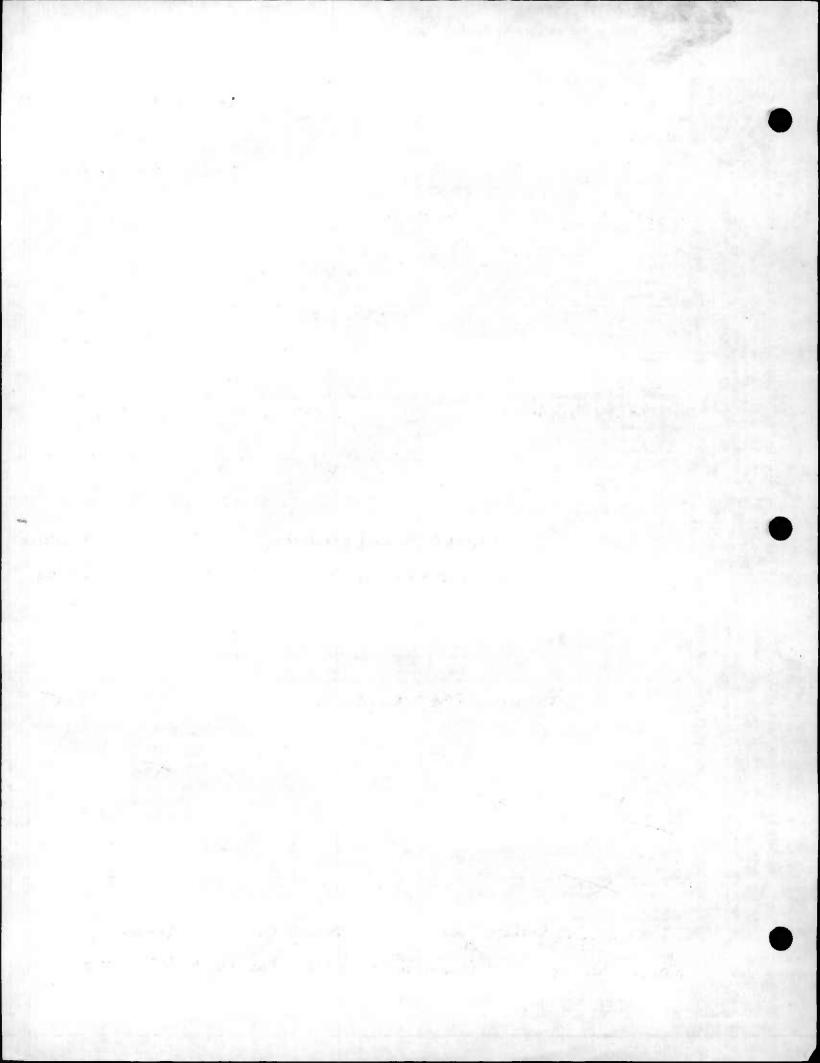
Registrar

8

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MORTIN WRITZ TSZS CRUWCY CT MORTIN 31. Dete filed (Month, Dey, Year)

32. Registrer's Signature

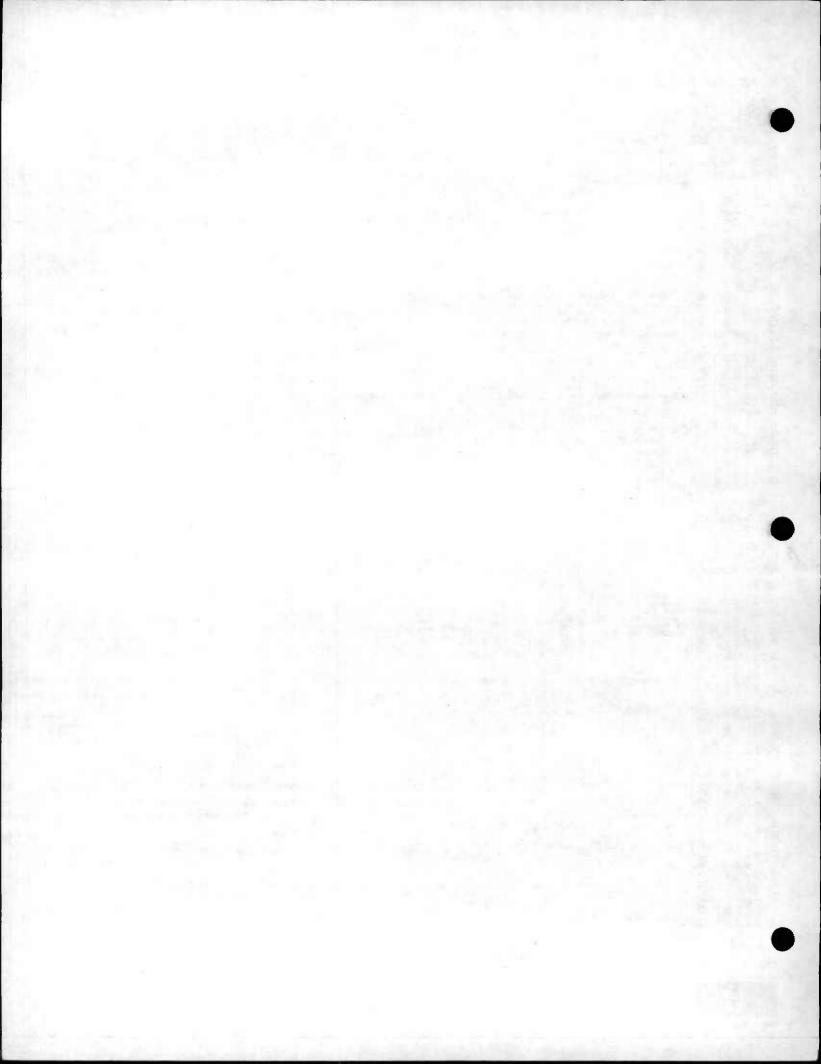


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** Ruth Asselin December 11, 1999 6:05 PM /Medical 4a Facility Nama (Il not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9816 Mahogany Drive, Apt. 101 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)

August 22, 1923 Rhode Island 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2\ F Days Hours Yrs. 76 Director 037-12-4763 Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 Yes 2 No Directo Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 8 the Medical Examiner must be 9816 Mahogany Drive, Apt. 101 'netural', or items 23s 20878 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ğ 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be life.
Department of Health and Mental Hyg important: If Item 27 is merked other any Injury or other traument. Dell 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Ernest England Mabel Bridgehouse 10 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Diane L. Thompson/Daughter 7104 Grinnell Drive, Rockville, Maryland 20855 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Dec. 15, Silver Spring, 1 Burial 2 □ Cremation 3 □ Ramoval from Stata 1999 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery Maryland 22. Nama and Address of FacilityRobert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 23a. Part1. EnteM Approximata Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical End Stage Renal Failure 1 year Examiner Dua to (or as a consequence of): Examiner Diabetes The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medicai Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Peripheral Vascular Disease Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was casa referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa SCSResidence 6 Other (Specify) 1 Yas 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Pending invastigation s after dea. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida in 24 hour.
the Funeral Direction Hospital 24 hours a 29a. Cartifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signatura and titla officertifia 29c. License number 29d. Data signed (Month, Day, Year) 021370 December 13, 1999 mu 12 30. Name and addrass by person who completed cause of death (Item 23a) (Type, Print) Raymond Bass M.D. 15225 Shady Grove Road, #302, Rockville, Maryland 20850 31. Date liled (Month, Day, Year)
DEC 1 4 1999 32. Registrar's Signatura State oaks

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

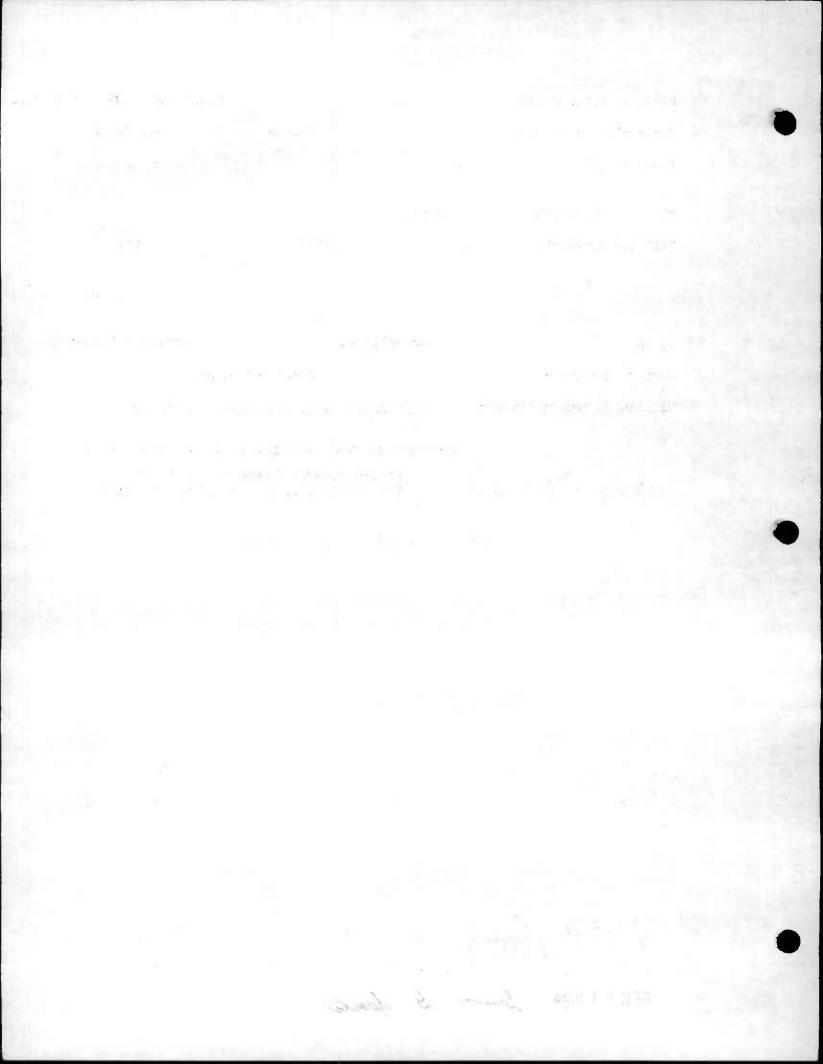
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** December 16, 1999 Betty Kathryn Beachy 12:28 a.m. /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 25, 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2X F Hours 193-24-7327 68 Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral', or items 23a or 28a-f show Director 1 ☐ Yes 2 No MD Baltimore Carney 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9127 Lamaze Road 21234 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White natural', Completed evant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Genealogist Genealogy Research 12 th other permit. Peges 1 and 2 should be flik Depertment of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic evant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sherman Brenneman Pearl Bittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William V. Beachy/husband 9127 Lamaze Rd., Baltimore, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Dec 18, 1999 Grantsville Cem. Grantsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 nou 179 Miller St., Grantsville, MD ause or complications that causad the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, and List only one cause on each line. 23a. Part1. Entor the Physician /Medical Immediate Cause (Finel disease or condition resulting in death) An crestic concer 7 months Examiner Due to (or as a consequence of) Exam Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24e. Wes an autopsy 2.20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: မှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the Ho within 24 to To the Fur completely 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) December 16, 1999 12 , mo 30. Name and addrass of parson who completed cause of death (Item 23a) (Type, Print) mes A Riley N. Charles St. Balto, mi 6701 6 BMC

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 1 1999

32. Registrar's Signary

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

And Facility Name (From earthbook, prov. pulser and numbers) 4. Facility Name (From earthbook, prov. pulser and numbers) 5. Social Socially Name (From earthbook) 5. Social Socially Name (From earthbook) 6. Social Socially Name (From earthbook) 7. And (From earthbook) 7. And (From earthbook) 8. Social Socially Name (From earthbook) 9. Social Social Name (From earthbook) 9.				Certifica	te of Death		Reg. No.	3 409/1		
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21. Signature of Funeral Service Licenses 22. Name and Address of Facility (W. R. PRICE FUNERAL Human CCO37L) 335 MAIN ST. MEYERSIDAUE PA 13 336 Peranti. Enter the diseases, or conglications that caused the death. Do not enter the mode of dying, such as cardac or respiratory errest. Indexes between the disease or condition resulting in death). 335 MAIN ST. MEYERSIDAUE PA 13 346 Peranti. Chief the disease, or conglications that caused the death. Do not enter the mode of dying, such as cardac or respiratory errest. Indexes and the content of the caused of the control of the caused of the content of the caused of the cause of the caus		1 Burial 2 □ Cremation 3 □I	Removal from State	cemetery, crematory or	other place)			-		
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20 Monday MD Dedu MD Dec 15, 1999 30. Name and address of person who completed cause of deeth (Nam 23e) (Type, Print) GI+NZMA QADIR 20311 LAPPAMS LOAD BDONS BOW MD 21713.	Ę			28b. Time of		28d. Describe how injury occurre				
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) G1+NWA RADIR LOST LOST BOWN BOWN BOWN BOWN ALTIS	Director: After Jin by the fun ertification	2 ☐ Accident investigation	(World, Dey Year)			- A				
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20	Ca	(Check only 2 Medical Exami	ner: On the basis of examina	owledge, deeth occurre ation and/or investigetio	d et the time, date and ptacen, in my opinion, death oc	ce, and due to the curred at the time,	ceuse(s) end mann date and place, an	er as steted. d due to the ceuse(s)		
20 MORAL MO DEC 15, 1999 MS GI+AZMA RADIR 20311 LAPPAMS LOAD BOONS BOWN MO 21713.	N N		and manner stated.	2	9c License number		20d Date signed /	Month Day Year)		
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) GI+N2MA QADIR LOS II LAPPAMS LOAD BDONS BOW MO 21713		Ma	ha o	-	N 1.1 -1		\ 16	1000		
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State of Maryland / Department of Health and Mental Hygiene Q 4,1979 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month 3. Time of Death **Physician** Edward B Blakeney 4:15pm 12-11-99 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Of Hyattsville Hyattsville Prince George If Under 24 Hrs. 5. Social Security Number 250-19-0610 If Under 1 Year 9. Birthplace (Steta or Foreign Country) South Carolina 8. Date of Birth (Month, Day, Year) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1MM 2□ F Days 39 Director 6-9-60 Usual Residence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George Hyattsville 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 20783 6500 Riggs 238 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural," or item any Injury or other treumatic event, the Medical Expenses. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2€No Specify: Specify: Black Yes Give p 3 ☐ Widowed 4 ☐ Divorced Year or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Security Officer Security 12th 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Ozzile Blakeney Eva Mae Newman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Harrison Blakeney (Brother 701 Chesapeake St S.E.#5 Wash DC 20032 20b. Place of Disposition (Nama of cematary, cremetory or other place)
AngelüsChapel Church 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 12-19-99 Jefferson S.C. 22. Nama and Address of Facility Sterling Funeral Service 21. Signatura of Bunaral Service Licensee 090 1601 Kenilworth Ave NE Wash DC 23a. Part1. Enter the dis-shock, or heart fail asa, of complications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** Immediata Causa (Finel disease or condition rasulting in death) /Medical Cardio-Respiratory Failure Examiner Dua to (or as a consequence of): Physician/Medicai Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in daath) Lest Dua to (or as a consequence of): for use as the burial-trar P.O. Box 68760, Wasting Syndrone Due to (or as a consequence of): Sepsis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy this certificate hes 1 Yes 2KINo 1 ☐ Yas 2 X No Attending Physician: director. 25. Was casa rafarred to medical 26. Place of Death (Check only one) 1□ Yas 2只大 Other: 4 turning Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Stytural 5 Pending invastigation s after deeth. 1 Yes 2/7/No 2 Accident XA the 6 Could not be datarmined To the Hospital or Atte-within 24 hours after de-To the Funeral Director completely filled in by th 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide 13 Sertifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only 29b. Signature and the of certification 29c. License number 29d. Data signed (Month, Day, Year) D42019 12-15-99 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Chowdhury 7350 Van Dusen St Laurel Md 20707 Imran 31. Data filed (Month, Day, Year) Registrar's Signature State **DEC 17 1999** Registrar

DHMH 16 Rev 6/95

SEC 1 1 1993

WRC 99-7496-510 **EBER BLANCO**

Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40980 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death DECEMBER 12, 1999 **Physician** EBER BLANCO 5:41 PM. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 180 M 2□ F Months Days Hours Director 579-19-9190 36 05-07-63 El Salvador Usual Rasidence of Decedent 10a Stata il Hygiene. other than "natural", or frams 23a or 28a-f show vent, the Madical Examinar must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Edgewood 1 Yes 2 No Director 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 646 Burlington Ct. 21040 El Salvador Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status flied within 72 hours after 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1√2 Yas 2□ No Specify:El Salvadoran Specify: Hispanic à 3 ☐ Widowed 4 ☐ Divorced Yaar or Detas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Landscape Company 8th Landscaper permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked oths eny Injury or other treumatic event, page. 17 Fathar's Nama (First Middle Lest) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Obdulio Blanco Elena Mejia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Maria Blanco (Wife) Edgewood, Md. 21040 646 Burlington Ct. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Sfata 1 Burial 2 Cremetion 3 Removal from Stata 4 Donation 5 Othar (Specify) Glenwood Cemetery 12/17/99 Washington, D.C. 21. Signeture of Funaral Service Licensee 22. Nama and Addrass of Facility
W. H. BACON FUNERAL HOME, INC. Bacon CCO361 3447 14th St., N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical GUNS HOT WOUND OF CHOST Examiner Due to (or as a consequence of) Examiner physicien end s the buriel-transit The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lest Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. been signed by the c should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate has b director, page 2 s 18 Yes 2 □ No TYPE 2 No Mospital or Attending Physicien:
 24 hours after deeth.
 Funeral Director: After this certification of the funeral director. 8 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1X Yes 2 No 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 1 Netural 5 Pending SHOT WAS Sous Jours 17001 1 Yes 2 No investigation 12-12-99 2 Accident 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 2005 BMV 85 / BUTHE RE WA CAN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Predicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signiffure and title of certifier 29c. Licensa number DECEMBER 13, 1999 O.C.M.E. 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) N 111 Penn Street, Baltimore, Maryland 21201 HD EYDOND Koron

Registrar

31. Dete filed (Month, Day, Year)

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32 Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Tima of Death Month 1:30 PM **Physician** 12 Brown nomas /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 4309 57th Avenue, #4 Bladensburg Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 8, 5. Social Sacurity Number 578–80–9422 9. Birthplaca (Stata or Foraign Country) Washington, D.C. 7. Aga (In yrs. lest birthdey) 1XM 2□ F 42 Yrs Usuel Rasidenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Maryland Prince George's Bladensburg Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4309 57th Avenue, #4 20772 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yas 2 ሺ No If Yes, Give Yaar or Detas: 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: **Black** þ 3 ☐ Widowad 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) 12th Electrician Private 18. Mother's Name (First, Middle, Maidan Surnama) 17. Fether's Nama (First, Middle, Last) Be Thelma Brown Florine Monroe 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Delois Cooper/Sister 3905 23rd Parkway, #11, Temple Hills, Maryland 20748 20b. Place of Disposition (Nama of cematery, cramatory or other place) 12/18 1999 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State Harmony Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) Landover, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME Percen 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Entar tha disease or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intervet Batween Onset end Deeth Immediata Causa (Final disease or condition resulting in deeth) Adenocarcinoma, Unknown Dua to (or as a consequence of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or es e consaquence of): Physician/Medical that initiated avents rasulting in daath) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Severe Cachexia py 24b. Ware autopsy findings eveilable prior to completion of cause of deeth? 24e. Was en autopsy Completed performad? 2 1 No 1 ☐ Yas 1 TYes 2 No Be 25. Was casa rafarrad to medical 26. Place of Death (Check only ona) axaminar? Othar: 4 Nursing Home 5 Residence 6 Othar (Spacify) 1 Yas 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Manper of Deeth 28b. Tima of 28d. Describe how injury occurred 5 Panding investigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Sulcida 281. Location (Street and Number or Rural Routa Numbar, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 112 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end dua to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at tha tima, date end plece, and due to the ceuse(s) and manner stated. 29a. Certifiar (Check only one) Medical

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: s efter de. Hospitai

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Madical Examiner must be notified an once.

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/Medical Examiner

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Saltimore, Maryland 21215-0020

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29c. Licansa number

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29d. Data signed (Month, Day, Year)

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	1. Decedent's Nema (First, Middle, Last)	2. Data of De	Reg. No.	3. Time of Death					
ian	EVELYN BRASLOW	Month DECEMBE	Day	Yaar					
ical ner		Town, or Location of Deat							
	HOLY CROSS HOSPITAL SILV	ER SPRING	MONTY	COMERY					
		dar 24 Hrs. 8. Data of Bi	rth	Birthplace (Stata or Foreign Country) PENNSYLVANIA					
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5	MADVE AND MONTHON THE			172 Yes 2□N					
DILECTO	MONICOMERY SILVER SPRING 10e. Street and Number		10g. Citizen of V						
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by Funeral	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? If Yes, specify Cuban, Maxid VXYas 2 □ No	of Hispanic Origin? (Specify Yas or No- tuban, Maxican, Puarto Rican, atc.)							
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	NATHAN BRASLOW		AIGA	ra)					
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	NORMAN BRASIOW / NEPHEW 269-Barwynne Lane			9096					
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		12/16/99 cility	12/16/99 Springfield, Delawar GOLDSTEINS						
	22. Name and Address of Fac 6410—NORTH BE PHILADET	7.07.0							
edical Examiner									
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	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa		1 Yes 2 No 3 Probably 4 Unknow						
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Yaar Month **Physician** Darius Sanford Bittinger December 11, 1999 3:00 a.m. /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 326 Sherman Hare Road If Under 1 Year If Under 24 Hrs. Hours | Min. Grantsville Garrett 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. Date of Birth (Month, Dey, Yeer) **Funeral** ₩ 2 D F Months 90 Vre Director 159-16-8726 Nov 11, 1909 Maryland Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumetic event, the Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County 2847 Foxtown Road, Grantsville 1 ☐ Yes 2 🖫 No Director MD Garrett 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2847 Foxtown Road 21536 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Metals Manufacturing 6 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Silas Bittinger Mary Maude Miller 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Raletionship (Type, Print) Sarah F. Broom/daughter 326 Sherman Hare Rd., Grantsville, MD 21536 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 XBurial 2 Cremation 3 Removal from State Grantsville Cemetery, Dec. 13, 99 4 ☐ Donetion 5 ☐ Other (Specify) Grantsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., PO Box 275 wnac 21536 Approximate 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or he or taken. List only one cause on each line. Interval Betwean Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical CARDIAC ARREST Examiner Examiner ORONARY Sequentially list conditions, if any, leeding to immediate causa. Enter Undarlying Causa (Disaase or injury attending physician and for usa as the burial-tran Physician/Medical that initiated evants resulting in death) Lest usa as ed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. signed by the 2 No 3 Probably 4 ☐ Unknown 1 Yes þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy parformed? page 2 should Completed peed 1 Yes 1 ☐ Yes 2 ☐ No certificate a Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified Be 25. Was case referred to medical 26. Placa of Daeth (Chack only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 10 1 Yas 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Mannar of Daath 1 Metural 28b. Time of Injury Certification: 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28c. tnjury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by tha 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, end dua to tha ceusa(s) end menner as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date end placa, end due to the cause(s) and manner stated. 29a. Certifiar Medical

State

29b. Signature end title of cartifier

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DEC 1 4 1999

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Registrar

Bisse 11 MD 32. Registrer's Signature

and addrass of parson who completed cause of death (Itam 23a) (Type, Print)

124 Miller St. GRAUTEUILL Md 21536

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29c. License number

00034231

29d. Date signed (Month, Dey, Year)

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Baltimore, Maryland 21215-0020

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P.O. Box 68760.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Day **Physician** JAMES EDWARD BAKER DECEMBER 1, 1999 2250h /Medical 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Yaar | If Undar 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) FEB. 22, 1946 9. Birthplaca (Stata or Foraign **Funeral** Months Hours 15 M 20 F ENFIELD. 579-58-4005 Yrs. 53 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No N/A Directo N/A WASHINGTON, DC flams 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 99 WEBSTER ST. NE #102 20011 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Bieck, Whita, etc. 1 ☐ Nevar Merried 2 ☑ Merried 1 ☐ Yes 2 TVNo If Yas, Give Yeer or Detes: natural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

TITLE N. 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) TRAINING OFFICER COUNSELOR College (1-4or 5+) DC GOVT. - OAK HILL FAC! 2 YRS. parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event. 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumeme) Be ERNEST BAKER DOROTHY BODY 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ANNIE L. BAKER/ WIFE 99 WEBSTER ST. #102 NE WASH., DC 20b. Plece of Disposition (Nema of 20e. Method of Disposition Date 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ROCK CREEK CEMETERY 12-9-99 WASHINGTON, DC 22. Name end Address of Fecility Marshall's Funeral Home of MD 21. Signeture of Funeral Service Licent 4308 Suitland RD. Suitland, MD Approximate Intervel Between Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heer feilure. List only one cause on each line. **Physician** /Medical Immedieta Ceuse (Finel disease or condition resulting In daath) days Acute Myocardial Infarction Examiner Due to (or as a consequence of): Examiner certificate be executed Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Couse (Disaase or injury that initieted events rasulting in deeth) Lest Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequenca of) The lew requires that the death P.O. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detach detach Obesity- hypoventilation syndrome 1 Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Wara eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? Severe (Morbid) Obesity completion of cause of death? Hypertension 1 ☐ Yas 20 No 1 ☐ Yes 2 1 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Pleca of Daath (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural deeth. 1 Tyes 2 No within 24 hours after deeth.
To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Cartifiar Medical 🖎 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, date and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stafed. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura end titla of certified D34590 12-2-99 SILVER, Md 30. Neme and address of person who completed cause of death (frem 23a) (Type, Print) ROY FRIED Kaiser Office, Holy Cross Hospital 1500 Forest Glen Rd. 20901 31. Data filed (Month, Dey, Year) 32 Registrar's Signatura State DEC 1 3 1999 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death Month 12 **Physician** ZORAH L. BOOKER 14 99 4:31 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 3, 1913 Birthplaca (State or Foreign Country)
 New York 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 050-20-9255 1 □ M 2 X F Yrs. 86 Director **Usual Residence of Decedent** 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits ahow Prince George's 1 X Yas 2 □ No Upper Marlboro Funeral Director Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò r than "natural", or hama 23a or the Medical Examiner must be 14100 Farnsworth Lane 20772 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11 Marital Status 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specify: Specify: Completed by **Black** 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide Private 12th Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flam 27 is marked ofth any injury or other traumatic avant ROGS. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Charles Brooks Lucy Wilson 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iona Bullock/Daughter 13700 Captain Marbury Lane, Upper Marlboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 🗓 Removal from State Rolling Green Memorial Park 1999 4 ☐ Donation 5 ☐ Other (Specify) West Chester, Pennsylvania 21. Signature of Funeral Service Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Partt. Enfer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on sech line. Approximata Interval Batween Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner I or Attanding Physician: The law requires that the death certificate be executed siter death.

Director: After this certificate has been signed by the attending physician and d in by the funant director, page 2 should be detached for use as the burial-transit d in by the funant director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760, to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 212 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 2 No 1 Yes 1 ☐ Yas 2 ☐ No Division of Vitai Be 25. Was cesa referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 No 1 Inpatient Certification: To 1 Yas 2 ER/Outpatient 3 DOA 27. Manner of Death Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atta within 24 hours ster de To the Funeral Directo completaly filled in by th 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the ceusa(s) end menner es steted. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

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3. Registrar's Signature DEC 1 6 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Laxmi Berwa, M.D.

31. Data filed (Month, Day, Year)

7700 Old Brach Avenue, #ClO1, Clinton, Maryland 20735

eee: 1 030

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 12 **Physician** Winnie Virginia Bullock 12 1999 11:55P.M /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1□M 25 F Months Days Hours Yrs. Director 226-32-5860 70 9/12/1929 Virginia Usuei Residence of Decedent 10a. Stete show 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at XI ☐ Yes 2 ☐ No Director P.G. MD Oxon Hill 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 1626 Fenwood Ave. 20745 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ♣☐ No If Yas, Giva natural', or items Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status 14 Race - American Indian filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Detes: Completed 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Private Housewife parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked other any Injury or other traumatic event once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Watt Coleman Dolly Ann Neal 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Bullock/husband 1626 Fenwood Ave.Oxon Hill MD.20745 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Dogation 5 ☐ Other (Specify) Forest 12/15/99 Clinton, Md. Hills Cem 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Hodges and Edwards 3910 Silver HII1 Rd.Suitland, Md.20746 awrun Park Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, anjuck, or heart feiture. List only one cause on each line. Approximete Interval Between Onsat and Deeth **Physician** Immediate Ceuse (Finel disease or condition rasulting in death) /Medical Chronic Renal Failure Examiner Hypertension Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaese or injury Due to (or es a consequance of): Box 68760. Diabetes Mellitis thet initiated events resulting in deeth) Last Due to (or as a consequence of) Respiratory Failure/required mechanical Ventilation P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown signed t Hypothyroidism, Vaginal Bleeding, Difficile Records, þ Be Completed 24b. Wara autopsy findings available prior to page 2 should 24e. Was an autopsy Colitis, Depression, Sleep Apnea, Bradyarrhythmia completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, s 25. Was cese rafarred to medical 26. Placa of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. tnjury at Work? 28a. Dete of Injury (Month, Dey Year) Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datermined 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida 29a. Cartifier (Check only one) 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34472 12/13/99 30. Name and address of person who completed cause of death (from 23a) (Type, Print) Lynne Diggs MD 1500 Forest Glen Rd. S.S.Md.20910 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture State Registrar BEC 1 4 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month Yan **Physician** Robert K. Bresnahan 1:54PM December 8, 1999 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Daeth 4c. County of Death Examiner Prince Georges Malcolm Grow Medical Center Springs If Under 1 Months 8. Data of Birth (Month, Day Year) Dec. 20, 1922 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1 1 2 □ F Washington DC Vm 76 578-20-1915 Director Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Insida City Limits Show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Examinar maint be notified at 1 ☐ Yes 2 ☐No Directo Maryland Prince George's Suitland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20746 6401 Randolph Road Funeral 14. Race - Amarican Indien, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stetus permit. Peges 1 and 2 should be filed within 72 hours effect Department of Health end Mental Hygiene. Important: If itsm 27 is merked other than "natural", or iter any Injury or other traumatic event, the Westral Example DRE. 1 ☐ Nevar Married 20 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 XXIVo Specify: White by 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11th Electrician Commercial 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Be Robert. K. Bresnahan Amy Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Margaret M. Bresnahan (Wife) 6401 Randolph Raod Suitland, Maryland 20746 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Othar (Specify) Ft. Lincoln Cemetery Dec. 11,1999 Brentwood, Maryland 22. Name and Addrass of Facility Lee Funeral Home, Inc. 21. Signatura of Funeral Service 1 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the distance of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. Approximata Intarvel Batweel Onset end Deet **Physician** Immediate Cause (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner physician end s the buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated events resulting in daath) Last Dua to (or as e consequance of) The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) 98 for use es signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No 2 24b. Wara autopsy tindings evallable prior to completion of causa of death? Completed 24e. Was en autopsy peen page 2 1 ☐ Yas 2 ☐ No 1 Yas 2 XNo certificate or Attending Physician: funeral director, Be 25. Was casa raferred to medical axaminar? 26. Place of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 15 Impatiant 2 □ ER/Outpatient 3 □ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No 2 Accident 24 hours efter deat Funeral Director: 6 Could not be determined 3 Suicida 28f. Location (Streat and Numbar or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At homa, farm, straat, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Phyeician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the bast of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and many or stated. 29a. Certifier Medical (Check only one) To the To the To the P 29b. Signature and title of or 29d License number 29d. Deta signad (Month, Dey, Year)

ed cause of death (Item 23s) (Type, Pgint)

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Penbrooke Square # 104, Waldorf, Md. 20603

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State Registrar 30. Name and address.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month **Physician** 0328 DECEMBER 11, 1999 Charlotte Roberta Buck /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of De Examiner CHEVERLY PRINCE GEORGES HOSPITAL CENTER PHINCE GEORGES If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Linder 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1□M 2☑F 90 261-05-1829 Director Aug. 16, Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-1 show any Injury or other traumatic event, the Modital Examinat must be notified. 1 ☐ Yes 2 No Prince George's Riverdale Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6208 Carters Lane 20784 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Bureau of Mines 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Charles Davis Margaret Emley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Great-5511 43rd Place, Hyattsville, MD 20781 Christeen T. Settle-Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 12/14/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 Dasc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final . HYPERTENAVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner HIIW COMPLICATIONS physician and s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last No (or as a consequence of) Physician/Medical Due to (or as e consequence of) attending pl signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown ò 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy is certificate has I 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 Suppatient 2 □ ER/Outpatient 3 □ DOA this funerai 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident after deet Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s)

29c. License number

274) (Type, Print)

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29d. Date signed (Month, Day, Year)

TOL PRIVE CHEVERLY MARYLAND 207.85

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

with the Meryland

Baltimore, Maryland 21215-0020

Hospital 24 hours a 24 hours To the Hosp within 24 hor To the Fune completely fi

or Attending Physician:

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State of Maryland / Department	of Health and Mental Hygiene

			Decedent's Name (First, Middle, L.	net)		Cen	ificate of	Dealli	2. Dete of De	Reg. No.		3. Time of Deeth
Drivital Records, P.O. Box 68760, hysician: The law requires that the death cartificate be executed this cartificate has been signed by the attending physician and an idirector, page 2 should be deteched for use es the bunat-transit and idirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit and indirector, page 2 should be deteched for use es the bunat-transit.	Physicia	n	September 11 and						Month Dey Yeer			6:10 P.M.
	/Medica		WILLIAM H. BA 4a Facility Neme (If not institution, gi		-			4b. City, Town, or Lo	Decemb			0:10 F.M.
	er				PATTON CE						rao la	
	Funeral		SAINT THOMAS MORE 1 5. Social Security Number 6.			last birthdey)	If Under 1 Yaar	Hyattsv If Under 24 Hrs.	8. Date of Bir (Month, De	Prince		eleca (Stete or Foraign
				1₩ 2□ F	86	Yrs.	Months Days	Hours Min.	Aug. 31			Jersey
	dend we		10e. Stete 10b. County		10c. City	, Town or Loca	ation				1	0d. Inside City Limits
	Man	į	Maryland Prince	e George's	в Ну	attsvil	le le					1 ☐ Yas 2 ☐ No
	or 28	je j	10e. Street end Number				10f. Zip Code	Q 6 m.		10g. Citizan of V	What Cour	ntry?
	23a (a	4915 Eastern Ave	nue, #303			2078	82		United	d Sta	tes
0	or items	/ Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedar Armed Force 1 Yes 28 If Yes, Give	s?			lispenic Origin? (Sp en, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ck, White,	ean Indien, etc.
000	urel',	d by	3 Widowed 4 Divorced	Yaer or Detes	5 :						B1	ack
15-	natu	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give ki	nd of work done	during most of work	ing	16b. Kind of Bu	usiness/Inc	dustry
12	212 J withir Jiene.	E C	Elementery/Secondary (0-12)	College (1-4o	r 5+)			0)		n		
9	Hygienther out, u		17. Fether's Neme (First, Middle, Las	t)		Mana	ger	18. Mother's Nem	e (First, Middle			
lan	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and infractor, page 2 should be detected for use as the bunal-transit and increase.	To Be	Causie Balla	rd				Leona	Obiah			
ary	shou md M mer	-	19a. fnforment's Name/Reletionship			19b. Meiling	Address (Street			er, City or Town,	Stete, Zip	Code)
	alth a 27 is 27 is		Mildred Ballard	l - Wife		4915 F	astern	Avenue. #	303. Hv	attsvil	1e. M	ID 20782
ore,	of He item		20a. Method of Disposition		20b. P	lece of Disposi	tion (Neme of story or other place	ce)	Dete	20c. Location -	City or To	own, Stete
E	Page nent of mr: M		1 ☑ Burial 2 ☐ Cremetion 3 [4 ☐ Donetion 5 ☐ Other (Special		.0				12/13/99	Laurel,	Mary	land
alti	mit. porta y inju		21. Signature of Funeral Service Lice	nsee		22.	Name and Addre	Usual Occupation I work done during most of working IT user streed) Priva 18. Mother's Neme (First, Middle, Maiden Sumeme) Leona Obiah Iters (Street end Number or Rurel Route Number, City or Town, State Itern Avenue, #303, Hyattsville, (Name of or other place) Onal Memorial Pk. 12/13/99 Laurel, Male and Address of Facility VART FUNERAL HOME, Inc. Benning Road, N.E., Washington, mode of dying, such as cardiac or respiratory arrast, Of): Of): Ing cause given in Pert I. 23b. Did tobacco use contribution of the place of the pla				
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10	Section.	1	23a. Part 1. Enter the disease, or con	nplicetions that caus	ed the deeth	Do not enter	the mode of dyir	ng, such as cardiac	or respiratory a	rrast,	on,	Approximete fntervel Between
В	Physician		gricon, or rical reliate. Elst one									Onset end Deeth
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п	1-18 PM		resulting in death)	0.		r es a consequ	-				1	
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60,	be e) ician buria	a E	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury	C								
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f V		0	exeminer? 1 ☐ Yas 2 ♣ No	Hospital: 1 Inpa	tient 2	ER/Outpetient	3□ DOA Oth	ner: 42 Nursing Ho	me 5 Res	denca 6 □Oth	ner (Specia	(y)
0	ng Ph ter th meral		27. Manner of Deeth 1 ØNaturel 5 ☐ Pending	28e. Date of fr (Month, I	jury De <i>y Year</i>)	28b. Time of Injury	28c. Injui Wor	ry et	28d. Dascribe	how injury occur	red	
Sio	endline or: A:	cati	2 ☐ Accident investigation					Yes 2 No				
Ξ	filer d filer d linect in by	Certification:	3 Suicide 6 Could not 4 Homicide determined	ZOU. FIECA OI	njury - At ho etc. <i>(Specif</i>)	ome, farm, stree /)	et, fectory, offica			Street end Numb wn, State)	ber or Rure	el Route Number,
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	(4)	-	30. Name and address of person who	completed source	I dooth //te-	23a) /Time B	1/1/)[7071	onioM	D 110/	49	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day Physician Barbara L. Berman November 29 1999 5:19pm /Medical 4a. Feclify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 20 F Yrs. Director 213-30-2576 May 11, 1932 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 XYes 2 No 28a-f Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? ò 230 2682 Wilkens Avenue 21223 United States Funeral Herns 1 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married b 1 ☐ Yes 2XNo Specify: þ Specify: 3 Widowed 4 Divorcad White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 麦 Joseph Charles Trabert Sr. Louise Estelle Towles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) into interpretate of Health important: If hen 27 is any injury or other treesones. . Marc A. Berman/Son 5542 Gayland Rd Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11-30-99 Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) CAncer 6 months Examiner Due to for as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Box 68760. physician the death certificate be Physician/Medicai thet initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown The law requires that by Records, pe Completed 24b. Were autopsy findings evailable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? certificete has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) (+ 05 pice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 ☐ Yes 2 No this 27. Menner of Death Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 5 Pending Investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident efter death 6 Could not be determined 3 Suicide in by t 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled edicai 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated. (Check only one)

Registrar

State

29b. Signature and tile of contiller

31. Dete filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.R. (ey (BM 670) N. Charles G-BINY 32. Registrar's Signeture 1 1999 0

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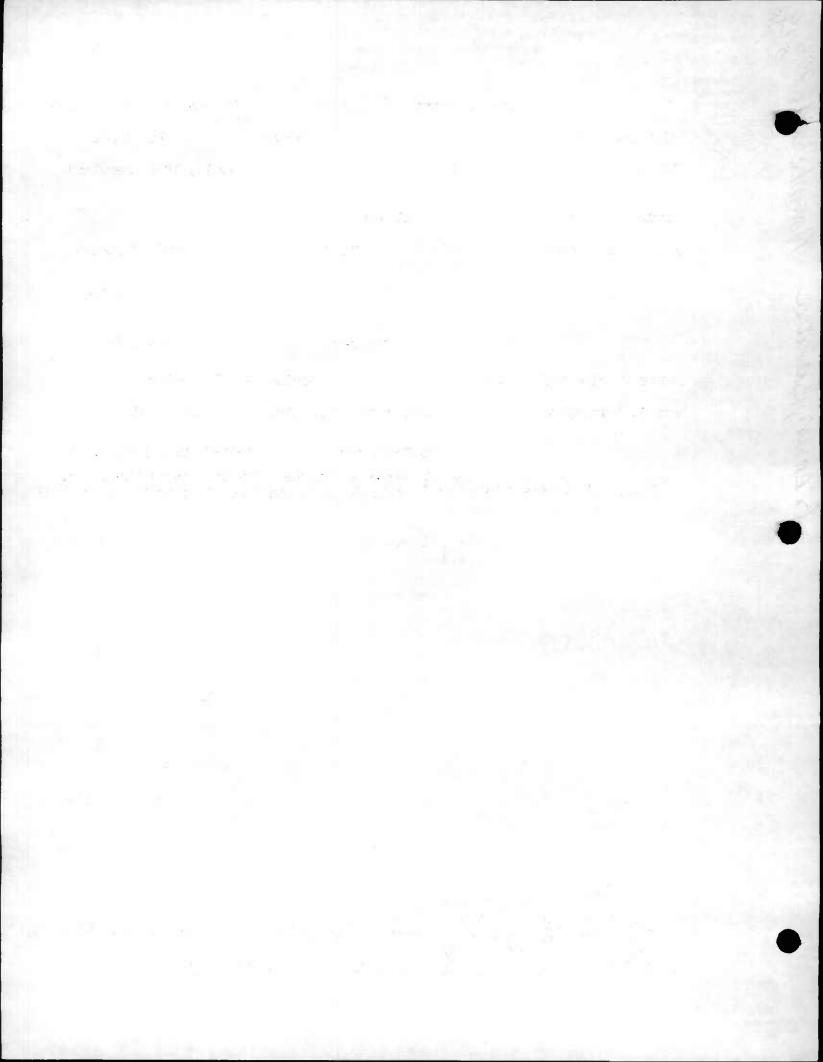
Balto. md 21204 N. Charles St.

29c. License number

29d. Date signed (Month, Day, Year)

November 30, 1999

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 12ALDWIN DEC Georg F /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deaf Examiner OLUM BIA Noward County Genera NOWAY 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 2, 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F Days 218-09-2516 82 Yrs. Maryland Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4621 W. Hill Road 21043 United States 14. Rece - American Indian, 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) flad within Elementary/Secondary (0-12) Collega (1-4or 5+) Letter Carrier US Postal Service 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be fitted that the Mental Hand Mental Hand: If Item 27 is marked oth ury or other traumatic even John S. L. Baldwin Irene E. Rose 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 4621 W. Hill Road Ellicott City, MD 21043 Virginia D. Baldwin 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: If he any injury or o 1X Burial 2 ☐ Cramation 3 ☐ Removal from Stata Loudon Park Cemetery 12-15-99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signatura of Funeral Sarvice License Ums-4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset end Death Physician Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, taading to immadiata causa. Entar Underlying Ceuse (Disease or injury that initiated events rasulting in daath) Last Box 68760. Physician/Medical Dua to (or as a consequence of): P.O. F been signed by the s should be detached Part II. Other algnificant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p Records. 24b. Wara autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificata Division of Vital or Attending Physician: Be 25. Was casa rafarred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To Inpatiant 2 ER/Outpafient 3 DOA this 27. Mannar of Death Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar 1 Netural 2 Accidant 5 Panding deeth. 1 Yes 2 No investigetion • Funeral Director: / 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the \$ 29b. Signatura and title of certifian 29d. Data signed (Month, Day, Year) em

State Registrar 31. Data filed (Month, Day, Year)

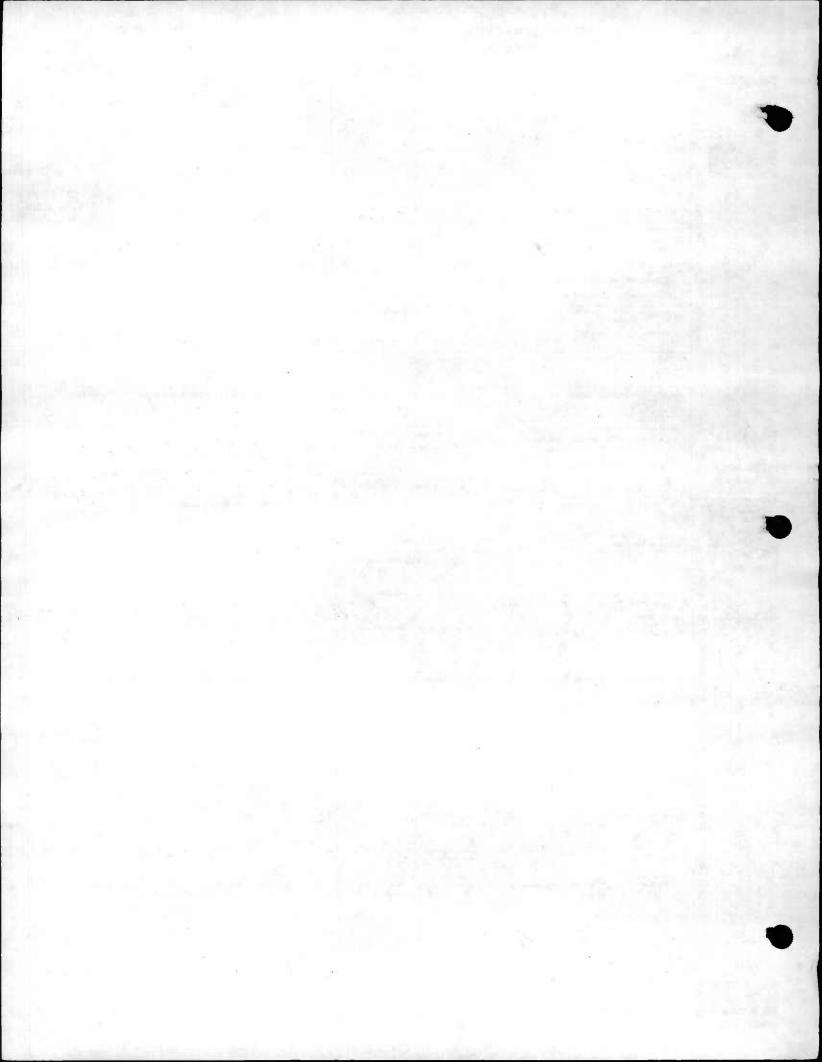
DHMH 16 Rev 6/95

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Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

MMN

32. Ragistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dey Month Beall Evelyn N. December 14, 1999 7:55 PM 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Regional Hospital Prince George's Laurel Laurel If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Deys Months Hours 1 M 2 ₩ F 217-28-8068 Aug 27, 1918 Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Prince George Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7906 Brooklyn Bridge Road 20707 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Wessey Poe Minnie Poe 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Russell W. Beall, Jr. /son 375 White Hall Rd., Arapahoe, North Carolina 28510 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery 12/17/99 Laurel, Maryland 21. Signature of Funeral Se 22. Name and Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart fellure. List only one cause on each line. ESOPHAGEAR ADENO CARCINOMA Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? ANEMIX 1 Yes 2 No 3 Probably 4 Unknown , SEP 515 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a Stete

MD

Director

Funeral

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Completed

Be

Funeral

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death with the Marylend

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylen Depertment of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28e-f show say highry or other fraumatic event, the Medical Examiner must be notified anones.

altimore, Maryland 21215-0020

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buriel-transit ettending physicien for use es the bune signed by t peed : hes certificete funeral director,

Physiclan/Medical Examiner

þ

Completed

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Certification: To

Medical

29e. Certifier

(Check only one)

29b. Signature at

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. or Attending Physician: 24 hours efter deeth. Funeral Director: After this filled in by Hospital pletely

20

within 2

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be determined 3 Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Dey Year)

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 Yes 2 No

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner steted.

28d. Describe how Injury occurred

281. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

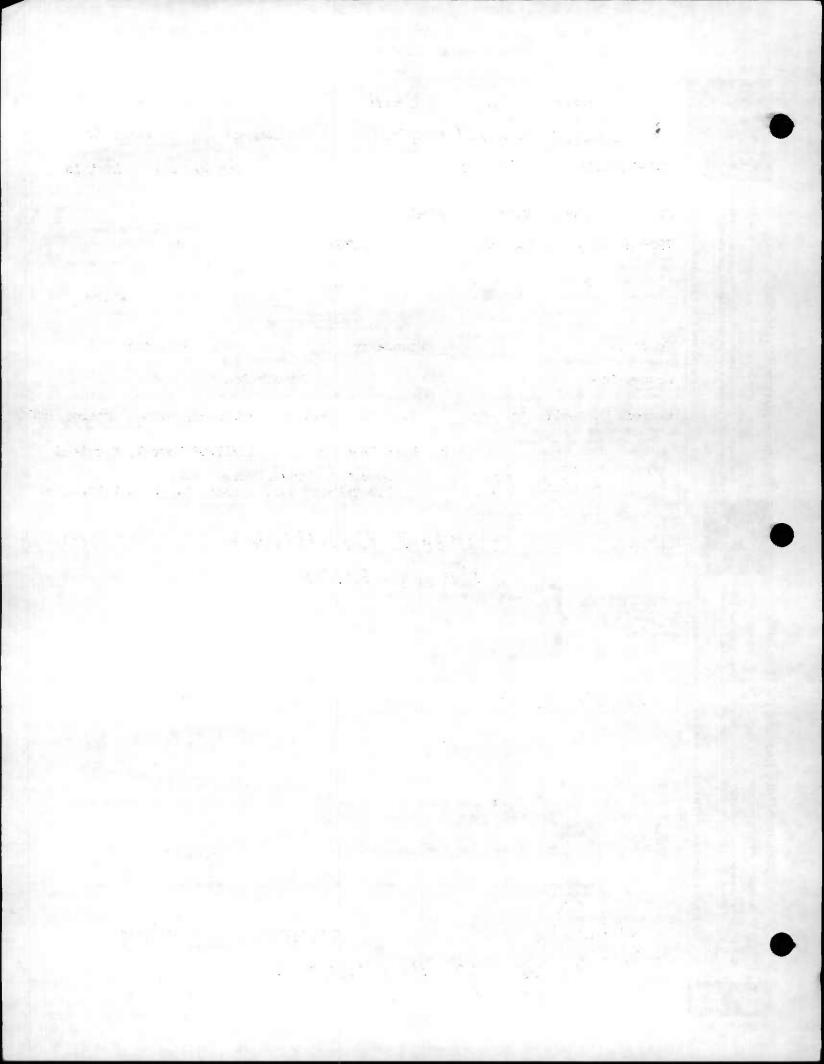
29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRINCE

Registrar

32. Registrer's Signeture

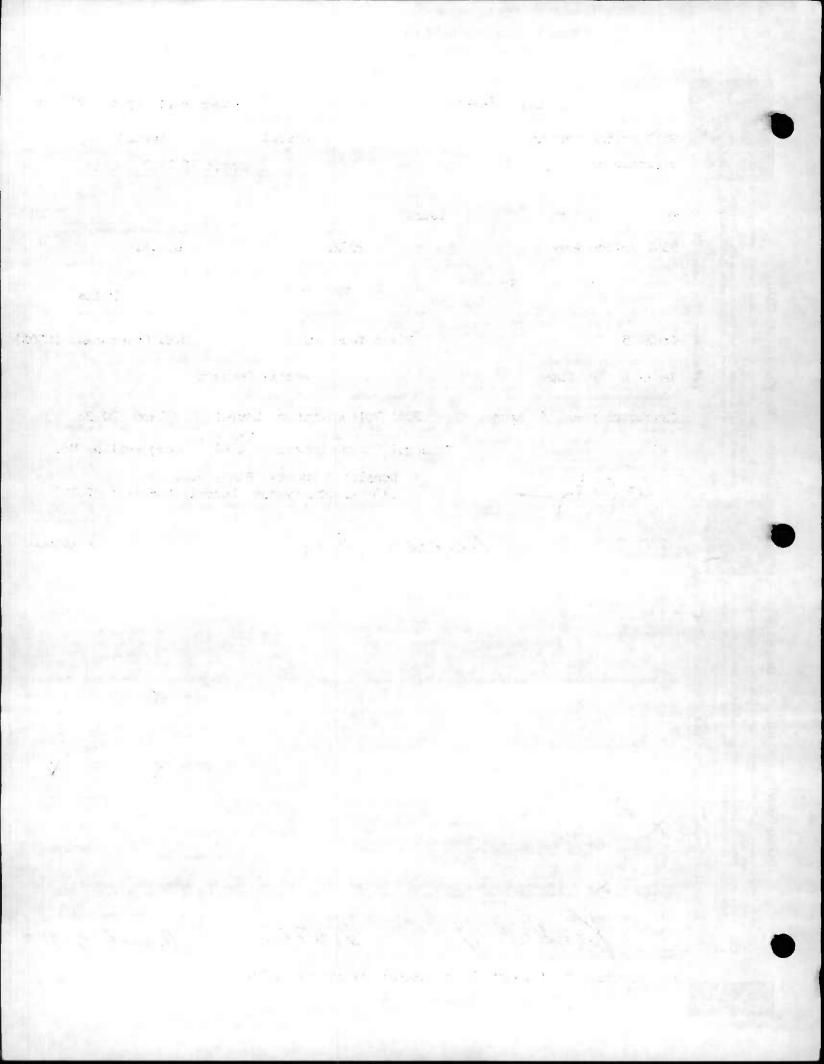


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State of Maryland / Department of Health and Mental Hygiene 99 4093

			Certifi	icate of	Death		Reg. No.				
Dhuaisian	1. Decedent's Nama (First, Middla, Last	Decedent's Nama (First, Middla, Last)				2. Dete of De Month	ath Day	Year	3. Tima of Death		
Physician Medical	Charl	Les Edward		Bass		Decembe	er 14, 1		3:00	am	
Examiner	4a Facility Name (If not institution, giva				4b. City, Town, o	or Location of Deat	h 4c. County	of Death			
	9551 Fulton Avenue		to as birth days) if	Undar 1 Yaar	Laurel		Howa		la an 10to to	as Familia	
Funeral Director	5. Social Sacurity Number 6. Se 214–28–9044	x 7. Age (In yrs. 72 72		onths Days	Hours M	n. March	16 1927	9. Binnp Coun	olaca (Stata d utry) 10	or Foreigi	
Jend #	10a. Stata 10b. County	10c. C	ity, Town or Location	on				1	0d. insida C	Ity Limits	
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United death with the Me	9551 Fulton Avenue	е		0f. Zip Coda 20723			U.S.A.		itry ?		
by by	11. Marital Status 1 □ Nevar Married XX Married 3 □ Widowed 4 □ Divorced	12. Was Dacedant Evar in U Armed Forcas? 1 ™ Yas 2 ☐ No If Yes, Giva Yaar or Datas:	If Ya	if Yas, specify Cuba		(Specify Yes or No arto Rican, atc.)		en Indian, atc. ite			
72 ho	15. Decedant's Edu (Specify only highast grad		16a. Dacedant'	s Usuel Occup	oation during most of w	vorkina	16b. Kind of B	usinass/Inc	dustry		
I Z1Z13-UUZU ed within 72 hours ef ygiene. rer than "naturel", or nt, fre Med cell Exem Completed by F	Grade 5	Collaga (1-4or 5+)	life. DO !	Techni	d)		U.S. Go	verni	ment (USDA	
Maryland 212 d 2 should be filed within the and Mentel Hygiene. 7 Is marked other than traumatic event, fre. To Be Comp	17. Fathar's Nama (First, Middla, Last) James Luther Bass					ama (First, Middla Lambert	, Maidan Sumar	na)			
should land Men and Me	19a. Informant's Name/Raletionship (Ty	rpe, Print)	19b. Meiling A	ddress (Street	end Number or	Rurel Route Numb	er, City or Town	Stete, Zip	Code)		
	Charlotte Bass /		9551 For	n (Nama of		Laurel, I	Maryland 20c. Location				
Dallimore, bemit. Peges 1 e Department of Hee mportant: If Item in yi injury or othe ince.	1 X Burlal 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licens	Em	manuel C		Cemetery		Scaggs	ville	e, Md.		
permit. Departmit. Departmit. Departmit. Departmit. Departmit. Departmit. Departmit.	> GryS. Kn		Dona	aldson	Funeral	Home, P		and	20707	7	
Physician	23a. Part1. Entar Va disaase, or Lompl shock, or haart failura. List mly or	icetions that caused tha daa na cause on each line.	th. Do not antar th	a moda of dyi	ng, such as card	iac or raspiratory a	rrast,		Approximat Interval Bet Onsat end	ta twaen	
/Medicai Examiner	Immadiata Causa (Final disaasa or condition resulting in death)	Neg	ug.		2 yes			aes			
je je		Dua fo (or as a consequan	ce of):							
executed in end faltransit	Saquantially list conditions, if any, laading to immediate ceusa. Enter Undarlying Causa (Disaase or injury	Saquantially list conditions, if any, laading to immediate									
X 66 / 60, entificate be executed ding physician end se es the burial-transit Medical Examir											
0 2 2 2	d.										
et the death of by the etterneteched for une Physician	Part il. Other significant conditions con	ntributing to daath but not ras	sulting In the undar	fying cause gi	van in Part I.	23b. Dld	tobacco use co	ntribute to	the cause	of death	
signed by d be detected by Phy						1 🗆	Yes 24 No	3 ☐ Prot	bably 4	Unknow	
aw requ							an autopsy ormad?	COL	ere eutopsy teilable prior templetion of deeth?	to	
a de						10	Yes 2 No	1[□Yas 20	No	
ysteion: The li ysteion: The li sis certificate ha director, page	25. Was case raferred to madicel				26. Place of D	aath (Chack only	ona)			,	
Physicien: 1 this certifice ral director, p	1 Yas 2 No	lospital: 1 Inpatient 2	ER/Outpetient	DOA Ot	har: 4□ Nursing	Homa 5 Rasi	idance 6 □Ott	ner (Specif	y)		
Attending Pi or death. ector: After the by the funeral	27. Manner of Deeth 1	28a. Data of Injury (Month, Day Year)	28b. Time of Injury		ryat rk? Yas 2 □ No	28d. Describe	28d. Describe how Injury occurred				
2 9 4 5 E	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicida datarminad	28a. Plece of injury - At homa, farm, straet, fectory, office building, atc. (Spacify)					28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)			n <i>ber</i> ,	
To the Hospital within 24 hours of To the Funerel Completely filled	29e. Cartifiar (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knoner: On the basis of examination and mannar stated.	owledga, death occation end/or investi	curred at tha ti gation, in my o	ma, data and pla opinion, deeth oc	ca, and dua to tha curred et the time,	cause(s) and m dete end pleca,	enner es si end dua to	teted. tha ceuse(s)	
Me Me	29b. Signatura and title of contiller	0		29c. Licans	sa numbar	,	29d. Date signe	d (Month,	Day, Year)		
اله)	Kund	uly	- 00-1 (7	030	67/6	,	Dece	ench,	14,19	799	
1	30. Nema end addylss of person who co				1 00=	07					
State	Dr. Kundrat 8317 31. Data filad (Month, Day, Year)	Cherry Lane 32. Ragistrar's Sign		Maryla	and 207	07					

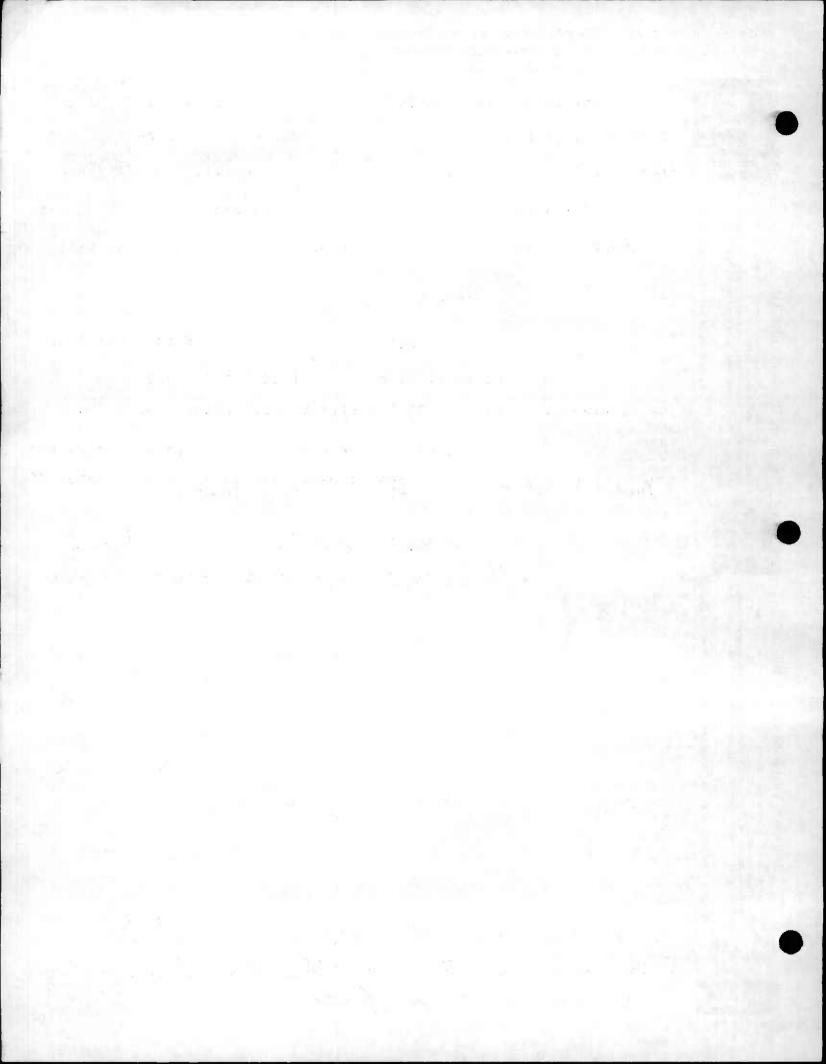
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State of Maryland / Department of Health and Mental Hygiene 99 40991

					Certifica	ate of [Death		Reg. No.	7 403	194					
Physicia	an	1. Decedent's Neme (First, Middle, Last		D.1				2. Dete of De Month			e of Death					
/Medica	al		Kenneth	Втас	les		h Chu Taum an		28, 199		30					
Examine	er	4a. Facility Name (If not institution, give 3297 Choptank				41	b. City, Town, or Prest			orDeath						
Funeral Director		5. Social Security Number 6. Se	_	(In yrs. last b	Yrs. If Uni	der 1 Year ns Days	If Under 24 Hrs Hours Min.	6. Date of Bir	th v. Year)	9. Birthplace (Sta Country) Marylai	ate or For					
>		Usual Residence of Decedent														
Ba-f ahov	ctor	MD 10b. County Carol		10c. City, To	vn or Location		Pr	eston		10d. insld	e City Li					
23a or 2	Funeral Director	3297 Choptank R	oad		10f.	Zip Code 216	55		10g. Citizen of What Country? United States							
- M	þ	11. Marital Status 1 □ Never Married 3/□Married 3 □ Widowed 4 □ Divorcad	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: ■		1□ Ves		ispanic Origin? (S in, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac Blac Specify	e - American India ck, White, etc. : White						
natu	Completed	15. Decedent's Edu (Specify only highest grad		166	a. Decedent's U (Give kind of	suai Occupe work done d	ation fu <i>ring</i> most of world	rking	16b. Kind of B	usiness/Industry						
than	du	Eiementery/Secondary (0-12)	College (1-4or 5+))					Eastor	n Hospit	t a 1					
r health and Mentel Hyglene. tem 27 is marked other than other traumatic event, the M		17. Father's Name (First, Middle, Last)	Mainte					me (First, Middle,								
enter c ev	To Be	and the same of th	is Natha	niel	Blades			Leora		. • ,						
and Mentel Hygiene. Is marked other than raumatic event, the M	F	19a. Informent's Name/Relationship (T)					and Number or Ri			State, Zip Code)						
Health a em 27 is other trau		Atha W. Blades/	Spouse	3	3297 CI	nopta	ink Rd.	, Prest	ton, Mi	21655						
Department of health important: If Item 27 any injury or other tr	ŀ	20a. Method of Disposition		20b. Plece	of Disposition (/	Vame of	i i	Date	20c. Location -	City or Town, Stat	0					
7 of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					emeter	v12/1	Presto	on, Mary	/1a					
important: If its any injury or ot once.		21. Signature of Funeral Service Licans	00		22. Name	and Addres	ss of Facility									
BESS		Mulay 7. 9	skow		Fram	ptom-	·Hawkin B, Fede	s-Eskov	v Funei	ral Home	≘,					
	T	23a. Part1. Enter the disease, or compleshock, or heart tailure. List only of	ications that caused th	ne death. Do	not enter the m	node of dying	g, such es cardia	c or respiratory a	rrest,	Approx	imate					
	ical Examiner						Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events		ue to (or as a	consequence consequence consequence	of):	liovasca	der de	isease .	2040	US
.= 0 1	in/Medical	reaulting in death) Last d														
e ettend ad for us	sicia	Part II. Other algnificant conditions cor	ntributing to death but	not resulting	In the underlyin	g cause give	en in Part I.	23b. Did	tobacco uae co	ntributa to the cau	aa of d					
	Phy							1 Yes 2 No 3 Probably 4 Uni								
s been sign	Completed by							24a. Wes	en autopsy med?	24b. Were autop aveliable p completion of death?	rior to					
ate hes page 2	E							10	res 2000	1 ☐ Yes	2 No					
ili o	Be	25. Was case referred to medical exeminer?					26. Place of De	eth (Check only o	one)							
0 0	2	1 ☐ Yes 2 No	lospitel: 1 Inpatient		utpatient 3		4 LI MUISING F	Home 5 Resi	dence 6 Oth	er (Specify)						
After th funeral	ion	27. Menner of Death 1. Naturel 5 ☐ Pending 2. Accident Investigation	(Month, Day	Year) 28b.	Time of Injury M	28c. Injury Work	(at k? Yes 2 □ No	28d. Describe	how injury occur	red						
Director: After d in by the fune	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							26f. Location (Street and Number or Rural Route Number City or Town, State)							
	edical	29a. Certifier (Check only one) 1 Certifying Physical Exami	aician: To the best of and manner state	xamination e	e, death occurrend/or investigati	ed el the tim ion, in my op	ie, date and piace pinion, death occu	e, and due to the urred at the time,	cause(s) and me date and piace,	anner as stated. and due to the cau	se(s)					
To the	¥ F	29b. Signature and title of cartifier		1		29c. License	number	a.	29d. Date pigne	d (Month, Day, Yes	ir)					
		Matthew Jose	sh Fisch	n N	10	152	251		11/29	199						
		0.00	, , , , , , , , , , , , , , , , , , , ,						/	-1						
		30. Name end address of person who co	empieted cause of dee	ith (Item 23a)	(Type, Print) 505 A	Det	Ehmene.	Lane	Caston	Mayland	2/					



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State of Maryland / Department of Health and Mental Hygiene 🝵 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Wilbur Butler December 16 1999 0951 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Cecil County Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days 186M 2□ F Hours Director 216-24-5356 April 29, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23s or 28s-f show Maryland 1 ☐ Yes 2 No Director Cecil North East 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 129 Bayside Drive 21901 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces December 1 Armed Forces December 1 Armed Forces December 18 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any hiury or other traumatic event, the Mexical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Engineering Department 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Butler Ethel Rumer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam Eleanor Butler 129 Bayside Drive North East, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor Memorial
Park 20a. Method of Disposition December 20 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 1920 4 ☐ Donation 5 ☐ Other (Specify) Elkton, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street North East, Maryland un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Acute Myocardial Infarction
Due to (or as a consequence of):
Coronary Artery disease tmmediate Ceuse (Finel disease or condition resulting In death) /Medical 2 Hours Examiner Physician/Medical Examiner The lew requires that the death certificate be executed the buriel-transi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Box 68760, Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. Records, P.O. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown b 2 Completed 24b. Were autopsy findings evailable prior to 24a. Was en autopsy performed? completion of ceuse of deeth? certificate hes 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was cese referred to medicel exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After t Division 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number Jacholus Mr 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
S. S. SACHDEV MD. 118 North St Suit 3B Elbron MD 21921 12 + I VA 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Data of Death 3 Time of Death **Physician** 16:10A Vecember /Medical Baltimore
Baltimore
Baltimore city, Town, or Location of Death 4a Facility Nama In not institution, give street and number) 4c. County of Death Examiner STUPS KINS 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🛛 F Yrs. 218-34-9077 61 Director Easton, MD Usual Rasidenca of Decedent 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location Show permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryle Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or itama 23s or 28s-f show any injury or other traumatic evant, the Medical Examinal must be notified at 1 Yes 2 No Director New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 Old Baltimore Pike 19702 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2K Warried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify If Yas, Giva Yaar or Dates: Specify: à white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Visiting Nurses Elamentary/Secondary (0-12) Collega (1-4or 5+) Nurse's Aid Assoc. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Lemuel Dyott Laura Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Bailey (husband) Newark, DE 19702 250 Old Baltimore Pike 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State Gracelawn Mem. Park 12/17/99 New Castle, DE 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Fecility McCrery Funeral Homes, Inc. 21. Signeture of Funeral Sect 3924 Concord Pike Wilm., DE 19803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated avents rasulting in death) Last Records, P.O. Box 68760. Physician/Medicai Dua to (or as e consec ncer of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ca signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa rafarred to medical Be 26. Place of Death (Check only one) examinar? Hospital: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Mennar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Pending ne Hospital or Attandin n 24 hours after death. The Funeral Director: After 1 Yes 2 No 2 ☐ Accidant invastigetion 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 29e. Cartifian 1 Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. To the To the F 29b. Signatura and little of certifier 29d. Date signed (Month, Day, Year) 30. Neme and addrass of person no completed cause of death (Item 23a) (Type, Print) War 10W 32. Registrar's Signature Registrar

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in the literal end of which

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death

1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey **Physician** DECEMBER 16,1999 6:55 PM SALLY MATILDA BORZA * /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner GENESIS ELDERCARE NURSING HOME LA PLATA CHARLES If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer)
AUG • 2,1914 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** 10 M 20 F Deys Months PENNSYLVANIA 578-54-5572 85 Director Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show with the Maryler r than "naturel", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 Yes 2 □ No Directo MARYLAND CHARLES LA PLATA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 1 MAGNOLIA DRIVE 20646 death Funeral Race - Americen Indian, Bieck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritef Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiana. Importanti if item 27 is marked other than "naturel", or ite any injury or other treumetic event 1 ☐ Yes 2 TNo If Yes, Give X Yeer or Dates: 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specify: Specify: ģ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be RICHARD REESE BERTHA MINER 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RONALD BORZA - SON 451 POPLAR LEAF DRIVE EDGEWATER, MD. altimore, 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 11 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) ST.MARY'S CEMETERY 12-20-99 BRYANTOWN, MARYLAND 21. Signature of Funeral Service License 22. Name end Address of Facility RAYMOND FUNERAL SERVICE, P.A. M00479 20646 LA PLATA, MARYLAND ions thet caused the deeth. Do not ente Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediate Cause (Finai diseese or condition resulting in death) Examiner Examiner sician and bunel-transit thet the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest to (or es e consequence of) P.O. Box 68760 Physician/Medical the Due to (or es e consequence of): 98 attanding p tha Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably Unknown þ 24b. Were autopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 1 Yes 215 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funaral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Aftar 1 Netural 2 Accident 5 Pending after death. Director: Af 1 Yes 2 - No investigation 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide A Hospital 24 hours a Funeral D 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medica

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end mannerstated.

cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

29c. License number

29d. Date signed (Month, Day, Yeer)

Registrar

completely

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(Check only one)

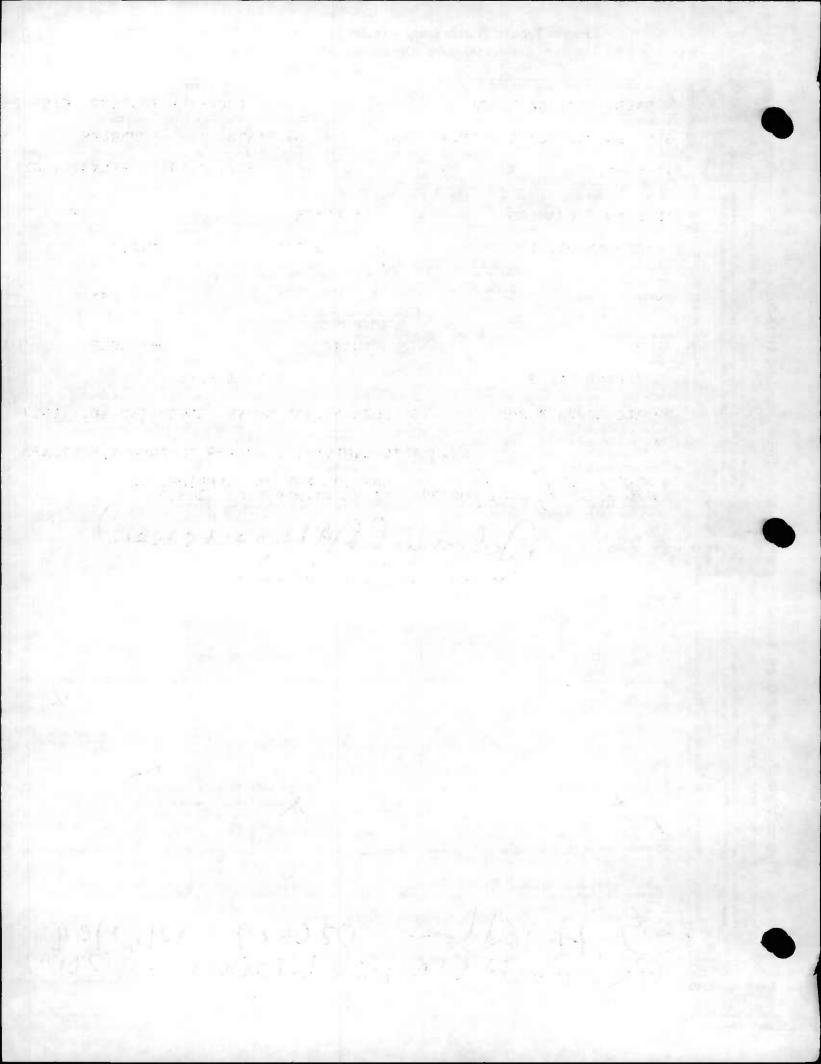
31. Date filed (Mo

29b. Signature and title of certif

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1999

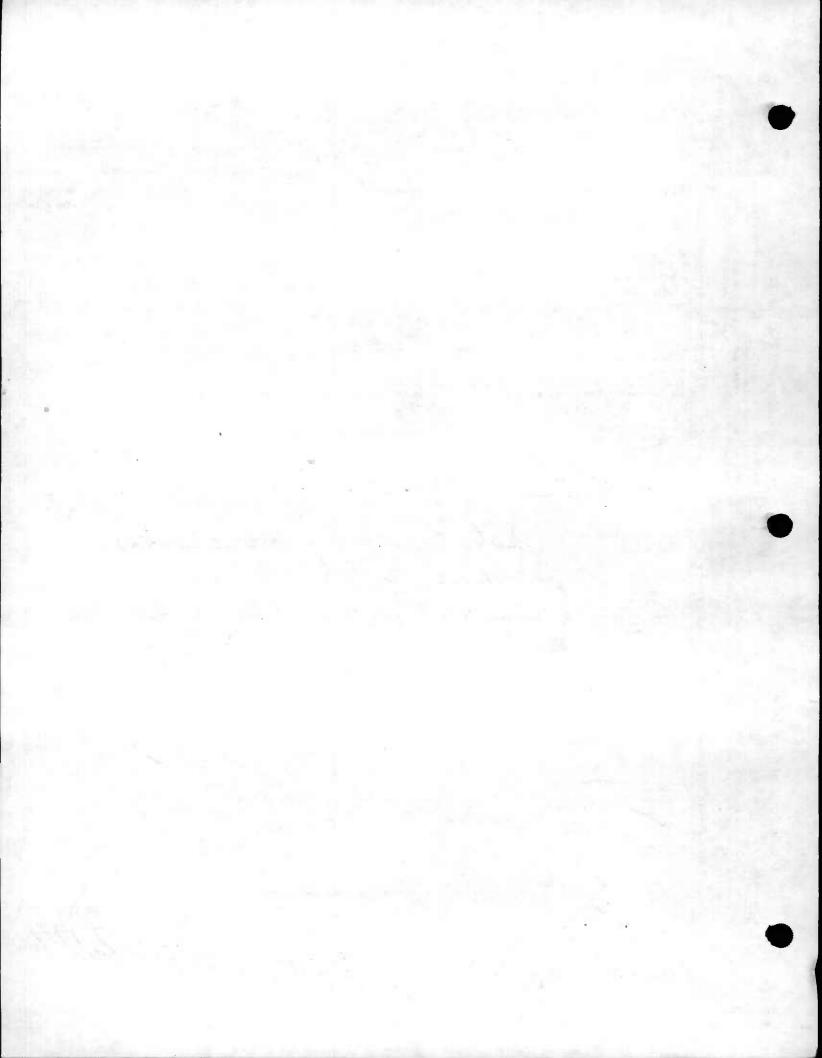


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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Emma Peters Brown /Medical 4b. City, Town, or Location of Death Ac. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Southern Maryland Hospital Prince George Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

January 13, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 79 Yrs 526-30-7091 Ohio Director 1921 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits 1 ☐ Yas 2 No Director Virginia Ronceverte Greenbrier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 5 U.S.A. 24970-1536 531 East Main St. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer d loppartment of Heelih and Mental Hygiene. Important: If itam 27 is marked other than "natural", or item any injury or other traumetic avent, the Medical Emerican page. Black, White, etc. 1 Never Married 2 Married 21215-0020 Specify: Black 1 ☐ Yas 2 XNo Specify: þ 3 ☐ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther Peters 2 Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Jerry Connelly 6550 Bock Rd., Oxon Hill, Md. 20745 20c. Location - City or Town, State 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition December 18,1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Funeral Services Alexandria, Va. 21. Signature of Funeral Service Lig 22 Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 de 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician GASTRIC CONTENTS Immediate Cause (Final disease or condition resulting in daath) /Medical **Examiner** Due to (or als Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a cop 88 esn signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? phoods 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation s after deeth.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) tilled in by 4 ☐ Homicida To the Hospital within 24 hours a To the Funeral Completely tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature 29d. Data signed (Month, Day, Year) 26352 isg of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Denera 1999 20 Registrar

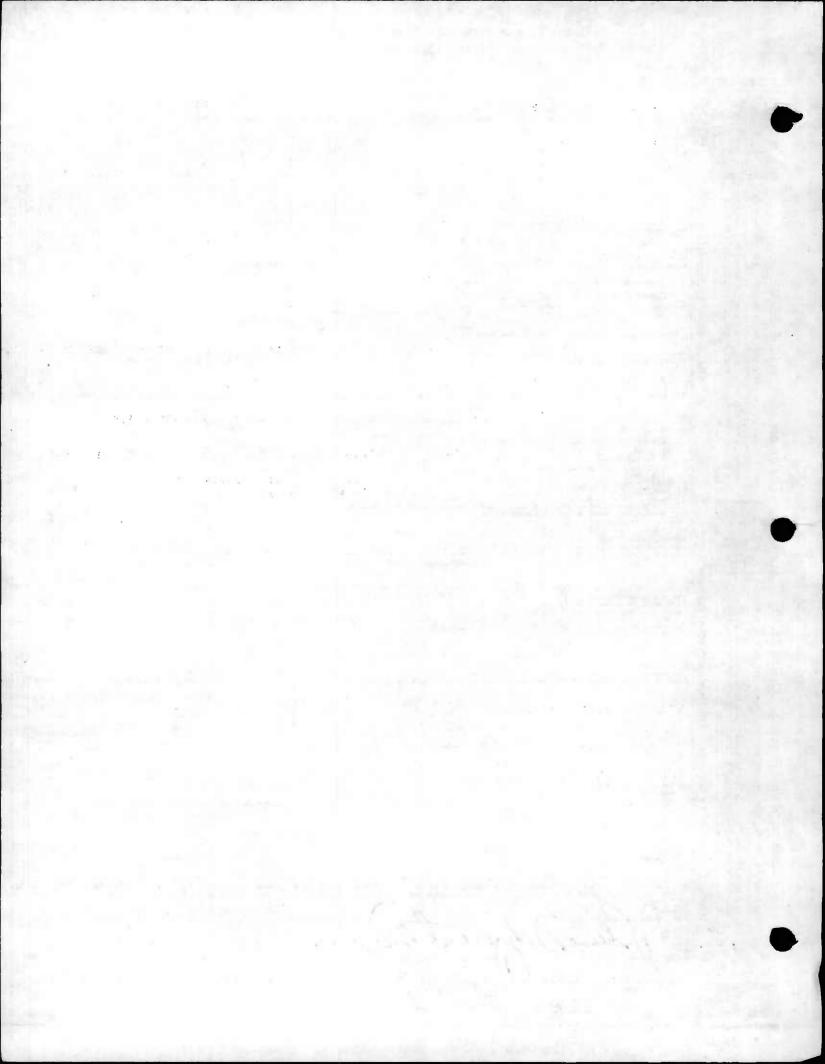


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. " 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** December 12, 1999 11:32 am John Walter Badaczewski, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5026 Adrian Street Rockville Montgomery If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 11XM 2□ F Yrs. Director 184-16-4361 Jan 27, 1922 Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No notifie Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be fled within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if them 27 is marked other than "hahural", or items 23s or lany injury or other traumatic event, the Medical Examiner must be 1 000s. 5026 Adrian Street Funeral 20853 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☑ Yes 2 ☐ No 1942—
If Yes, Give
Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White 3 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) DarCars Elementary/Secondary (0-12) College (1-4or 5+) Automotive Group Executive Vice President 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Walter J. Badaczewski Anna Witkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Badaczewski, Jr./Son .5026 Adrian Street, Rockville, MD 20853 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ol Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/16/99 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leiture. List only one cause of reach line.)00les 500 University Blvd., W, Silver Spring, MD Approximete Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a Adenocarcinoma Prostate with Metastases to Abdomen Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown Coronary Heart Disease þ Records. 24b. Were eutopsy lindings available prior to Completed 24a. Was an autopsy performed? Chronic Congestive Heart Failure completion of cause of death? certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai Aortic Stenosis To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, it Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Exp r: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29b, Sig 29d. Dale signed (Month, Day, Year) lery 15 D 01948 December 14, 1999 ol deeth (Item 23e) (Type, Print) 8218 Wisconsin Ave., Suite 408, Bethesda, MD 20814 Blaine Fitzgerald M.D. 31. Date liled (Month, Day, Year) 32. Begistrar's Signature DEC 15 1999 oaks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Death December 10, 1999 **Physician** LAWRENCE BAILEY 2:30 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10500 Rockville Pike, Apt. #404 Rockville Montgomery 6. Sex 1XXM 2□ F If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) July 5, 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 577-60-1748 87 Kansas Director Usual Residence of Decedent death with the Maryland 10a. Stete 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiens. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant, the Medical Empires must be notified another. 10b. County 10d. Inside City Limits 1 Yes 2 □ No Directo MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10500 Rockville Pike, Apt. #404 20852 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 전 Yes 2 □ No 1945— If Yes, Give Year or Dates: 1946 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Merital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Justice 5+ Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Zachariah Bailey Mary G. Kent 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mary A. Bailey / Wife 10500 Rockville Pike #404 Rockville, Md. 20852 20b. Plece of Disposition (Name of cematary, cremetory or other place) 20e. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Dec. 13 4 □Donetion 15X Other (Specify) Entombment Gate of Heaven Cemetery Silver Spring, Md. 1999 21. Signature of Epneral Service Licensee 22. Nema end Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or much failure. List only one cause on each line. Approximata Interval Batween Onset and Deeth Physician OBSTRUCTURE Pulmonn Immediata Causa (Final diseasa or condition resulting in death) /Medical Examiner Examiner The law requires that the deeth certificate be assocuted physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): USB BS for use as 23b. Did tobacco use contribute to the cause of death? signed by the aid be detached to Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert It. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy findings available prior to completion of cause of death? been si 24a. Wes an autopsy performed? Completed s certificata has b director, page 2 s 1 Yes 20No 1 Yas 20 Vo To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director, 25. Wes casa refarred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Tes 2 No 2 ☐ Accident 6 Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To carifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end dua to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to the cause(s) and manner steted. 29a, Certifian Medical (Check only one)

State Registrar

15

31. Date filed (Month, Day, Year) **DEC 14** 1999

29b. Signeture and title of certifier

Joseph

32. Degistrar's Signatura

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Kaplan, M.D.

18111 Prince Philip Dr. #327 Olney, Maryland 20832

29c. License number

735631

29d. Date signed (Month, Day, Year)

